The University Of Sheffield.

Medical Education in the United Kingdom: A post-structural critical policy analysis

Peter James Bazira

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Education

The University of Sheffield

Faculty of Social Sciences

School of Education

March 2017

Acknowledgements

I would like to acknowledge the tireless support of my wife Celia and children Sean and Amy, without whom this academic journey would not have been completed. Their unlimited patience, prayer and encouragement have seen me through innumerable mountains and valleys.

I also owe a lot of thanks to David Hyatt, my supervisor and mentor, whose patient and gentle persistent pressure throughout the course of the research for this thesis kept me grounded.

Finally, and most importantly, without God this would be both meaningless and impossible. To Him goes my undying thanks and sincere appreciation.

Abstract

Medical education in the UK is regulated by the General Medical Council (GMC), which among other things, formulates and publishes policies to effect this regulation. The latest GMC policy on medical education was published in July 2015 and came into effect on 1st January 2016. As educational organisations and educators endeavour to implement the latest GMC policy therefore, I contend that it is both fitting and germane to seek to provide a critical understanding of the policy by analysing its heritage, ramifications and significance.

The literature on policy studies in medical education, and engagement with policy by medical education organisations and educators are meagre, in spite of the abundance of policy covering this area. This work presents a post-structural critical policy analysis of the 2015 GMC policy, in the light of its preceding policies published in 1993, 2003, and 2009. It uses documentary evidence and applies the study of problematisation in and of policy to the discursive representation of policy problems, evaluating how these have evolved and transformed in light of the prevailing sociopolitical contexts, and critically analysing and reflecting on the implications and significance of these problem representations.

It finds that the GMC policies hinge on the problematisation of medical education as an issue of patient safety, educational prerequisites and the workforce demands of an increasingly decentralised and marketised health service. It argues that this problematisation is situated in notions of individual responsibility, marketisation and social accountability, and is underpinned by a reliance on the asymmetrical union of neoliberal and socialist ideologies.

The findings might be particularly useful to medical educators and educational organisations who have an interest in contributing to the development of further medical education policy. This work will contribute to the body of policy studies and medical education literature and, it is hoped, stimulate further research into medical education policy.

Contents

Acronyms

1 Introduction

Medical education, as a distinct form of higher education, is socially important because it provides a means for self-improvement, improved quality of life and social mobility. It is also of distinctive importance to United Kingdom (UK) society because it forms the foundation upon which the provision of high quality healthcare may be built, and because of the direct relationship that such provision has with the maintenance of the health of the public. In the UK particularly, medical education is quite often sequestered away from the changes imposed on higher education in general, perhaps because of its direct link to the provision of a workforce for the National Health Service (NHS). Further, the intimately intertwined relationship between medical education and the NHS in the UK make it an issue of such notable political relevance that the state a) allocates significant amounts of higher education and healthcare-related funding towards it (Chan, 2015), b) rigidly determines the number of students enrolled in undergraduate medical courses on the basis of projected healthcare workforce needs (The Health and Education National Strategic Exchange [HENSE], 2012), and c) enacts specific legislation, such as the Medical Act 1983 and the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010, aimed at regulating medical education and ensuring its compliance with governmental agendas.

Being a matter of such sociopolitical consequence therefore, it could reasonably be surmised that policy formulated for the regulation and governance of medical education would provide significant fodder for public policy analysis. However, a search of the literature quickly reveals that the body of published material on medical education policy analysis itself is remarkably small. For instance, searches of the academic databases PubMed, ScienceDirect® and Scopus® for the keywords “medical education policy

analysis" return no results. While using the Boolean " 'Medical Education' AND 'policy analysis' " on these databases yields more results, the majority are unrelated to medical education policy analysis. Similarly, a search for "medical education policy analysis" on Microsoft Academic returns nineteen results of which only two have to do with policy analysis in medical education (Knapp, 2002; Musick, 1998). A similar search on Google Scholar® only returns four results, while using the Boolean described above on the same search engine marginally increases the yield to five results (Menasco-Davis, 2014; Palaoğlu, Demirören, Aytuğ-Koşan, & Kemahli, 2012; Musick, 1998; Hammick, 1995; Vander Linde, 1989). Even taking account of the relative paucity of this literature, what exists primarily consists of analyses from North America that are focused to a large extent on the appraisal of the cost-effectiveness and the financing of medical education in specific contexts (Menasco-Davis, 2014; Schwartz, 2012; Millis, 1971). From the UK point of view, while the policies published by the General Medical Council (GMC) have been the subject of some critical analysis, the majority of the studies in this area have approached the policies from the perspective of the governance and regulation of the medical *profession*, with little or no emphasis on medical education itself (Salter, 2007, 2003, 2001; Allsop, 2006). To add to the problem of the lack of a focus on medical education in policy analyses, those whose responsibility it is to implement medical education policy itself, are rarely if ever, involved in critically analysing it. In fact, most of the critique of medical education policy and related policies in the literature emerges from the field of sociology rather than that of medical education. This apparent lack of critical engagement with policy within the field of medical education means that educators are not provided with a professionally accessible means by which they can challenge or contribute to the very policies which directly or indirectly regulate their profession.

As a medical educator myself, I recognise the direct influence of the policies of the GMC on my identity and profession, and on the identities and practice of the learners that my colleagues and I are responsible for. Without such a means to critically engage with these policies, educators are left bereft of the ability to understand and contribute meaningfully to relevant policies, to effectively challenge and resist those aspects that would be detrimental to the profession and to medical education in general, and to play an active part in their own governance. With the advent of a brand new policy for medical education in the UK, dubbed "*Promoting excellence: standards for medical education and training*" (General Medical

Council [GMC], 2015c), I therefore contend that it is imperative that critical engagement with these policies should begin, in order that medical educators can begin to actively contribute to the process by which they are governed, and thus positively influence the educational experience of our learners.

However, there is no one approach to analysis by which such critical engagement with medical education policy may be undertaken. In fact, there is a plethora of methods, methodologies, traditions, paradigms and approaches utilised in the analysis of policy. These are all dependent on specific understandings of the concept of policy and how it applies to various fields. They are also dependent on the outcome(s) sought for in policy analysis. It is evident therefore that one's epistemological approach to the concept and purpose of policy determines how one tackles it, and what outcomes one seeks, from its analysis.

In this thesis, I have approached UK medical education policy from an interpretivist paradigm, in which I focused on the meanings that the policy has for medical educators and learners. Electing to utilise an interpretivist approach has enabled me to focus on the analytical disclosure of meaning-making practices, and thus to disclose how they have been, and are being leveraged at a deeper social level to generate particular desired policy outcomes. I applied this approach to the critical analysis of the seminal medical education policies formulated and published by the GMC – the current *Promoting Excellence* (GMC, 2015c) policy and the preceding *Tomorrow's Doctors* (GMC, 2009, 2003, 1993) policies. My focus was on the meanings and meaning-making practices that were and are implied by the strategic use of language and discourse in the policies, and I sought to unveil the multiplicity of meanings embodied and transmitted by these means. My attention was focused primarily on the way in which 'problems' and their respective 'solutions' have been expressed and represented in the policies, and the meanings that could be derived from them, with the aim of resolving the policy into apprehensible targets – the representations of the policy problems – and I aimed to elucidate the ways that these problem representations are being utilised in the governing of medical education. I therefore sought to answer the overarching research question "**What are the problems represented to be in UK medical education policy?**"

My ultimate goal in this thesis has been that, by finding answers to this research question, I will have helped to lay a foundation upon which UK medical education policy(ies) can begin to be demystified,

and to provide an accessible means, for medical educators in particular, by which these policies can be critically engaged with, challenged, improved and contributed to. This aim builds on Ozga's (2000) sentiment in which she eloquently asserts:

> "I want to encourage a wide range of people to become involved in research in education policy. I want to remove 'policy' from its pedestal, and make it accessible to the wider community, both as a subject of study and a possible research area. In doing this I am arguing – implicitly and explicitly – that policy is to be found everywhere in education, and not just at the level of central government, and that there is virtue in engaging with policy in this way, because it contributes to a democratic project in education, which in turn contributes to democracy as the creation of an *informed*, *active citizenry* …" (Ozga, 2000, p. 2, emphasis mine)

Such engagement with policy and policy studies by medical educators would enable their (our) active critical involvement with the means by which they (we) are governed, and would help them (us) challenge the "misuse or simplification of research by policymakers, who denigrate or ignore research that does not support their chosen policy direction, while claiming to be committed to 'evidence-based policy making' " (Ozga, 2000, p. 2).

This thesis is thus focused on the idiosyncracies that distinguish medical education from other forms of higher education provision, and is a post-structural critical analysis of contemporary UK medical education policy formulated by the GMC. The history, heritage and evolution of this policy, previously entitled "*Tomorrow's Doctors*" (GMC, 2009, 2003, 1993), in the two decades since its first enactment in 1993 is explored, and the contemporary policy is analysed in light of both its predecessors and the socio-political contexts in which they were formulated or published. It is thus also a diachronic analysis of UK medical education policy from 1993 to 2015.

In order to lay a background and contextual foundation of the study, this thesis begins in chapter 2, with a brief exploration of UK medical education, its history and regulation, and an overview of its contemporary evolution. It continues in chapter 3 with a discussion of the literature relevant to policy and policy analysis, and an exposition of the underlying theory upon which the study stands in order to locate this work academically. Following this exposition of the literature and theory, I have discussed and justified the choice of methodology and procedures that I applied to this work in chapter 4, while chapter 5 forms

the main body of the critique and analytical work on UK medical education policy. In chapter 6, I have summarised the key findings, drawn conclusions and recommendations, and reflected on my intellectual journey in order to bring the thesis to a close.

2 Background and context

2.1 Introduction

Medical education is a commonly used notion that usually invokes images of a formal process of instruction aimed at the production of doctors. In spite of this familiarity, there is no consensus as to a singular definition of the notion (Whitehead, Hodges, & Austin, 2013; Bonner, 1995; Boelen, 1994; Pickering, 1956). On one hand, it may be used to describe both the proverbial 'means to an end', that is the creation of doctors, and a focus on the quality of the end-product of the process, that is a *good doctor* (Whitehead, Hodges, & Austin, 2013). On the other hand, medical education is also used to describe a rite of passage or a mechanism of "induction into the medical profession" (Grant, 2012). However, medical education is far more than the proverbial sum of these parts, but is a broad notion that encompasses all the processes, methods and activities involved in preparing individuals to attain, maintain, improve and use all the knowledge, skills, and attributes of a *good doctor* competently and in a fashion that is both accountable and beneficial to society (Whitehead, Hodges, & Austin, 2013; Bleakley, Bligh, & Browne, 2011; Swanwick & Buckley, 2010; Boelen, 1994).

In practice, medical education is a continuum that commences as individuals undergo preparation for admission to medical school. It then continues beyond entry into medical school to include all the formal and informal undergraduate and postgraduate education, and experiential training that prepares these individuals for independent medical practice, as well as all the learning and experience gained as a qualified medical practitioner (Swanwick & Buckley, 2010; Calman, Temple, Naysmith, Cairncross, &

Bennett, 1999). For the purposes of descriptive convenience, but also along the lines of formal provision, the continuum is divided into pre-medical, basic (undergraduate), postgraduate and continuing medical education.

Pre-medical education refers to the period of preparation to enter into formal medical education. It is usually limited to the final years of higher secondary education for school leavers, or for graduates of other disciplines, the time spent retraining and preparing to take graduate assessments for entry into medical education.

Basic medical education refers to that portion of formal provision that covers the training, teaching, and learning of students leading to the acquisition of a licensable medical qualification. In the UK, basic medical education continues beyond graduation from university into the first foundation year of postgraduate training in the NHS. In the UK, basic medical education is provided exclusively under the oversight of medical schools, which in turn are located within universities. In the UK, basic medical education is provided in the form of four, five or six-year undergraduate degree courses. Five or six years is the normal length of courses for students without a previous undergraduate degree, while graduates from virtually any discipline who successfully pass a graduate-level entrance examination may be accepted onto accelerated four-year courses.

In view of this primary oversight by university based medical schools, basic medical education is therefore also conveniently thought of as the *undergraduate* or the *university phase* of medical education. Unfortunately, both terms ('undergraduate' and 'university phase') convey the mistaken perception that basic medical education occurs exclusively in the setting of a university. In fact, while the power to confer basic medical degrees in the UK is an exclusive right of universities empowered to do so by the GMC (GMC, 2013c), the vast majority of training, teaching, learning and other educational activities undertaken during this phase of medical education occur in NHS facilities such as hospitals, community practices and general practice surgeries, under the supervision and direction of practising medical professionals, many of whom may not have formal academic relationships with universities (Brice & Corrigan, 2010; Eagles, 2005; Leinster, 2004). For the purposes of clarity however, I will use the term "undergraduate medical education" throughout this thesis wherever necessary, to emphasise the intimacy of the relationship between UK basic medical education and other forms of higher education.

Postgraduate medical education covers the instruction of junior doctors – those who lack the required training, qualification, experience and license to permit them to practice independently. In the UK, postgraduate medical education is generally carried out as a vocational apprenticeship in the professional workplace setting covering both specialist and general practice training, and leads to a wide range of professional specialist qualifications (Ovseiko & Buchan, 2011). Finally, *continuing* medical education is that part of the spectrum that covers the ongoing professional development of qualified doctors in practice, keeping them up-to-date with changes in medical knowledge and skills. Medical education therefore only ceases upon complete retirement from the medical profession (Swanwick & Buckley, 2010; Calman et al., 1999).

The focus of this thesis is on the middle portion of the medical education continuum, that is the undergraduate and postgraduate phases, primarily because it is this part of the continuum with which the policies in question are predominantly concerned, but also because of my own professional involvement as an educator in this part of the continuum.

2.2 UK medical education: a historical view

A cursory glance over the spectrum of UK medical education would lead to the mistaken inference that it has always been delivered in a more or less homogeneous fashion (Bonner, 1995). In fact, until the middle of the nineteenth century, there was little agreement by those who provided medical education, and by those receiving it, on what it constituted. Medical education had erstwhile been the preserve of the privileged social classes, and was provided and regulated by anyone that thought themselves competent to do so, whether this was individuals, medical schools, corporations or apothecaries (Bonner, 1995).

The majority of those who would eventually practice medicine at that time, received their training as apprentices to physicians, surgeons, apothecaries and barbers, with a small minority, particularly those of a higher social standing, receiving it in universities (Bonner, 1995). However, there was no minimum amount or duration of educational or professional experience that was required to be able to practice

medicine. In fact, there were no agreed minimum criteria for registration, when it eventually came into effect, or for a licence for medical practice.

Unfortunately, this fragmented approach to medical education meant that even those practitioners that had received their training within a stone's throw of each other did not receive similar education, nor could they be regarded as having comparable knowledge or skills (Wear, 2000; Poynter, 1958). It was thus virtually impossible to make a clear distinction between those doctors who were genuinely qualified to carry out their professional functions, and the charlatans and quacks (Poynter, 1958). With this precarious background, and on the basis of a) the overwhelming evidence of harm inflicted on unsuspecting patients by unqualified and unlicensed medical practitioners, b) the need for the public to be able to distinguish between those medical practitioners who were qualified, and the charlatans, and c) the need to respond to the demands of the developing medical establishment, the UK parliament debated and enacted a new piece of legislation in 1858 – the Medical Act 1858. This new law instigated the institution of minimum standards of training, and made the possession of a national license mandatory before any individual could engage in medical practice (Bonner, 1995; Waddington, 1990; Poynter, 1958; Thomson, 1958).

The enactment of the Medical Act 1858 simultaneously established an independent regulator for medical practice which it dubbed the "General Council of Medical Education and Registration of the United Kingdom". This new regulator was charged with supervising and controlling the training of doctors, ensuring that only those medical practitioners who were properly trained would receive a licence to practice following completion of their basic training, and regulating the medical profession (Irvine, 2006). From the outset, perhaps because the length of its official title was a significant mouthful (Addison, 1950), the General Council of Medical Education and Registration of the United Kingdom was more often referred to as the General Medical Council (GMC), a name which it formally adopted in 1951 (Poynter, 1958).

The enactment of the Medical Act 1858 also undercut the powerful corporations, royal colleges, and apothecaries that had previously controlled medical education, by legally transferring the responsibility and authority for its regulation to the GMC. However, because the GMC was primarily composed of

registered medical practitioners, as well as representatives of these influential organisations from its inception, and indeed for a long time thereafter, it essentially functioned as a legally sanctioned cartel for the self-regulation, promotion and protection of the medical profession and the interests of these organisations. The medical corporations, societies, and royal colleges represented on the GMC therefore retained sufficient power to influence the direction of medical education and to award licensable qualifications (Bonner, 1995). The GMC's activities were thus commonly, and perhaps correctly, construed by the general public as a mechanism for the protection and promotion of the values and interests of these organisations and medical profession as a whole (Bonner, 1995; Poynter, 1958; Thomson, 1958).

2.3 UK medical education: regulation

Although the GMC clearly had the statutory role of regulating medical education from the outset, in the early years it did not actively seek to enforce this role any more rigorously than by merely establishing the minimum age, qualifications and duration of training necessary for entry into the medical profession (Bonner, 1995; Poynter, 1958; Thomson, 1958). This seeming lack of engagement in the active regulation of medical education by the GMC may have stemmed from the fractious relationship between the corporate bodies whose representatives comprised the GMC, and whose consensus was necessary for the enforcement of its policies. (Bonner, 1995, p. 259). In fact, for a long time the policies of the GMC were often regarded as mere opinions and propositions without the force of law that could safely, and indeed legally, be ignored (Bonner, 1995, p. 194). By the late nineteenth century, however, the GMC and the corporate bodies that comprised its membership had managed to reach consensus to the extent that they defined a list of educational activities and outcomes that qualifying doctors would need to have undertaken successfully, and had agreed upon a set of common criteria for qualifying examinations for all medical education courses (Bonner, 1995, p. 259).

During the same period, new legislation in the form of the Medical Act 1886, repealing and replacing the Medical Act 1858, was enacted. Drawing on the strength of the more definitive statutory authority conferred upon it by the Medical Act 1886, the GMC took on an increasingly active role in the accreditation

of qualifying *examinations* (Harvey, 2010). However, it still did not play any significant role in the accreditation of UK medical education *courses* until yet another amended and updated version of the Medical Act (the Medical Act 1950) explicitly conferred these powers upon it (Sinclair, 1957).

Coincident with the establishment and entrenchment of the GMC in the nineteenth and early twentieth centuries, was a growing perception among the wider medical fraternity of a need to take advantage of the rapid increase in scientific knowledge, and an equally pressing need to incorporate the benefits of these intellectual breakthroughs into the already established apprenticeships and experiential training typical of medical education then (Bonner, 1995). There was also increasing pressure, particularly from mainland Europe and North America, where medical education was already established as a university discipline, for the UK to conform to the trend of university-based medical education (Bonner, 1995). These external and internal pressures propelled the UK, very slowly but surely, away from the delivery of medical education by an unstructured system of private apprenticeships, and towards its delivery in a more formally standardised, university based and centrally regulated structure. By the start of the twentieth century therefore, there was a demonstrable surge in the delivery of medical education by universities, and a concomitant downturn in that delivered by medical corporations and apothecaries (Clarke, 1966).

By 1944, with World War II in full force, the Coalition government under the leadership of Winston Churchill instigated the establishment of an interdepartmental committee, dubbed the *Goodenough Committee* after its chair, to investigate the state of medical education in the UK. This was partly done as a scoping exercise in preparation for the imminent establishment of the NHS. The Goodenough committee recommended that the delivery of medical education in the UK should be the exclusive preserve of universities working in collaboration with the emerging NHS (Goodenough et al., 1944). It is the implementation of these recommendations in the wake of the establishment of the NHS in 1948, that entrenched medical education as an integral part of both the NHS and UK higher education (Cohen of Birkenhead, 1968; Walker, 1965).

2.4 Tensions, revolution and reform

Between 1948 and the 1990s, the GMC continued to operate as a semi-autonomous organ of self-regulation of the medical profession, and concerned itself primarily with the registration and licensing of medical practice (Poynter, 1958; Thomson, 1958). From the early 1990s and thereafter, the GMC began to escalate its regulatory role. This was in the wake of a series of public scandals involving medical personnel and NHS organisations that were widely reported in the news media, such as that involving Dr Harold Shipman (The National Archives [TNA], 2005) and that of the Alder Hey Childrens Hospital (BBC, 2001a), and in response to the controversies and criticisms relating to the actions and responses of the GMC to these scandals (Irvine, 2006; Smith, 1997, 1993, 1989).

The overwhelming media, public and political pressures resulting from these scandals and controversies thrust the GMC into the limelight. This compelled the GMC both to restructure itself and to initiate in-house procedures to standardise and reinforce all of its regulatory activities (Irvine, 2006). The overarching aim of the restructuring was to reinvent the GMC as a socially accountable regulator of medical professionalism, licensure, education and clinical governance. In this new light, it would overtly present itself as being responsible for the standardisation of medical education and the oversight of medical curricula, in addition to its role as a regulator of medical practice (Chamberlain, 2009; Irvine, 2006; Keighley, 2004). Further, the reinvention of the GMC as a *socially accountable* regulator was effectively a strategic move to wrest the control of UK medical education away from medical schools, and into the hands of the GMC (Rees & Jolly, 1998, p. 255).

This reinvention of the GMC coincided with the widely expressed need for it to respond to ubiquitous complaints of fact-heavy medical curricula, the exponential increase and fast-paced changes in the body of medical knowledge, and the drive towards diversification and modernisation of medical curricula (Rees & Jolly, 1998). The GMC therefore proceeded to actively develop plans to institute and formalise universal guidance for the delivery of UK medical education. These plans culminated in the publication of the first iteration of *Tomorrow's Doctors* (GMC, 1993), the seminal medical education policy for the UK.

In what would be seen as a significant break with its insignificant past, for the first time since its inception the GMC stipulated that all medical schools in the UK, without exception, had to explicitly implement the requirements of its medical education policy (Irvine, 2006, p. 207). Regardless of the reason(s) for its formulation and publication, *Tomorrow's Doctors* (GMC, 1993) thus became central to the regulation of UK medical education, and was subsequently revised, reformulated and substantially updated in 2003, 2009 and 2015 (GMC, 2015c, 2009, 2003).

The restructuring of the GMC continued through the 1990s and early 2000s, albeit at a slower pace, culminating in 2010 with the absorption of the 'Postgraduate Medical Education Training Board (PMETB)', the erstwhile regulator of postgraduate and specialist medical education, by the GMC. As a result of this absorption, the GMC subsumed the legal functions of the PMETB over specialist and general practice training, and subsequently positioned itself as the sole regulator of the entire spectrum of UK medical education (GMC, 2013e).

The GMC in its current form is an independent body responsible to the government, the medical profession, patients, the NHS and society at large, to license only those doctors who meet a set of rigidly prescribed competencies and qualities, and to regulate the entirety of both medical education and medical practice (Irvine, 2006; Keighley, 2004). It is overseen in its role by the Professional Standards Authority for Health and Social Care which, until 2012 was the Council of Healthcare Regulatory Excellence (Keighley, 2004). While its main activities are the registration and regulation of medical practice, and medical education and training, the primary responsibility of the GMC is overtly stated as being to the public rather than to the medical profession (GMC, 2013e; Harvey, 2010). It is therefore seen, and strives to be portrayed, as an advocate for patients and society at large and not, as it had once been, an entity for the self-preservation and promotion of the medical profession (GMC, 2013e; Harvey, 2010; Bradby, Gabe, & Bury, 1995; Stacey, 1992).

It is widely recognised that these more socially cognisant changes resulting from its restructuring have been comprehensive, fundamental and conceptually irreversible (Salter, 2001; Samanta & Samanta, 2004). An unforeseen result of this is that now the perception of UK medical education in the literature is more consistently one of a managed social process of enculturation and socialisation into the medical

profession (Mann, 2010). The structural and perceptual changes to the regulator and its policies however, whether pertinent, responsible or timely, have received cautious yet mixed responses. For instance, the GMC is still being branded both in the literature and in the news media as "unwieldy, slow, defensive, and constrained in its powers" (Dewar & Finlayson, 2001, p. 689), "a doctors club" (Chamberlain, 2009; White, 2003), "bureaucratic" (BBC, 2003) and even " out of touch" (Crane, Cary, Risdon, Green, & Vanezis, 2010).

Importantly however, this institutional restructuring did not occur in isolation but proceeded concomitantly with the publication and imposition by the GMC of significant changes in policy and governance of UK medical education. In fact as discussed above, beginning with *Tomorrow's Doctors* (GMC, 1993) the GMC ramped up its publication engine, publishing a far-reaching array of policies, guidance, recommendations and information on an equally broad spectrum of issues related to the regulation and governance of medical education and practice. The impact of these publications has not gone unnoticed but has been variously analysed, reported and discussed in the medical education literature, in the news media and even more recently in social media.

Unfortunately, in my own view, the majority of the analysis of the GMC restructuring has focused rather myopically on the impact of its policy on narrow and restrictive areas of medical education, invariably missing the proverbial forest for the trees. For instance, Crilly, Glasziou, Heneghan, Meats, and Burls (2009) and Monkhouse and Farrell (1999) focused on the impact that GMC policy had on the delivery of specific subjects in medical school curricula, Boursicot and Roberts (2009) on its impact on diversity and inclusion, Steele (2011) and Stephenson and Stephenson (2010) on admission and selection practices, and Peters, Lynch, Manning, Lewith, and Pommerening (2016) on the resilience of medical students. What is lacking from the literature is an all-inclusive broad-spectrum view of GMC policy from the perspective of medical educators.

In this thesis, I have taken such an all-encompassing analytical view of how GMC policy, in particular its most recent publication *Promoting Excellence* (GMC, 2015c) which came into effect at the start of 2016, has been and is being utilised to create a scaffold around UK medical education, in an attempt to ensure its development and remodelling in particular sociopolitical dimensions. In the same way that foundations determine what type of building can be erected, the preceding historical treatise thus

sets the stage upon which this analysis can begin to make sense of contemporary UK medical education policy. It helps to illuminate, through a historiographic lens (Gale, 2001), the influence of the prevailing sociopolitical environment on the regulatory and policy activities of the GMC, and thus helps to highlight the exploitation of selective problematisation in UK medical education policy.

2.5 Linguistic underpinnings

That said, the gist of the message contained in the lead up to, and the public responses resulting from, the restructuring of the GMC is that the strategic use of language has been important in driving the changes, altering both the GMC's role and policies, and in guiding the responses to these changes. Language is, of course, vitally important to the interactions and transactions that are constituent to medical education, as for any other aspect of social life, as is evidenced by the sheer magnitude of literature dedicated to the use of language in doctor-patient and inter-professional communications (Iedema, Piper, & Manidis, 2015; Haddara & Lingard, 2013; Ainsworth-Vaughn, 2001; Bové, 1995).

The key issue in the strategic use of language in the medical context, just as it is in any other social context, is not merely the communication of information but rather the creation and sharing of meaning. As Waitzkin (1989, 1984) argues, the meaning, implication and effect of communication in the doctor-patient context is determined by a complex interplay of factors such as the social statuses of the doctor and the patient, the individual perceptions of their interaction, and the specific circumstances in which that interaction takes place. The use (or 'misuse') of spoken and written language in the medical context is often-times a source of considerable distress, or even a life-or-death issue to patients and other recipients of healthcare (Fallowfield & Jenkins, 2004; Hargie, Dickson, Boohan, & Hughes, 1998). In fact, the use of language in the medical context is considered so important by the GMC as to warrant the explicit inclusion of communication skills training in medical curricula (GMC, 2013f, 2009, 2003, 1993). However, the use of language to transmit meaning in communication is not limited to the domain of medical encounters but is integral to virtually all social contexts (Portner, 2005; Bourdieu, 1999; van Dijk, 1997; Ball, 1990). The use of language and the related notion of *discourse* are also central to all forms of policy and to policy analysis.

As the core of language, words in themselves are merely a socially constructed and agreed upon collection of letters, syllables, morphemes, phonemes and sememes. While some single descriptive words (such as 'blue', 'light' or 'dead') may have a relatively fixed and socially agreed meaning, the significance, implication and effect of words or phrases used in a collection (such as in texts or in speech) is determined by a complex interplay of factors such as the status of the individuals, groups and/or organisations using the words, the way the words are used, the context in which they are used, and the semantic representations applied by those that use the words (Portner, 2005; Bourdieu, 1999; van Dijk, 1997; Ball, 1990).

The use of language in such social interactions, in both oral and non-oral utterances utilised in communication (such as speech, writing and sign language), as a repository of social knowledge and memory, and as a form of social practice, forms the core of the sociological concept of *discourse* (Weiss & Wodak, 2008; Mills, 2004; Parker, 1990).

In this thesis I have focused on the strategic use of language, the discourse inherent to UK medical education policy, and the meanings and implications that are thus transmitted. I expand further on the notion of discourse in my discussion of the theoretical framework of this thesis in section 3.2.1 to follow. Nevertheless, I have discussed above the history of medical education and the evolution of the GMC as its regulator, and briefly touched on the role of the use of language in relation to policy and medical education generally. This discussion leaves the key issues, in this thesis, of policy and policy analysis obscure and unarticulated. In the following chapter (chapter 3), I have discussed the literature relevant to policy and policy analysis, and undertaken an exposition of the underlying theory upon which the thesis stands in order to locate this work intellectually.

3 Literature and Theory

In this chapter, I have the dual aim of locating this thesis within the literature, and establishing the theoretical framework (both ontologically and epistemologically) upon which the thesis is based. I further intend to locate my understanding of policy and policy analysis in order to set the stage for my analytical work on UK medical education policy. To this end, I begin in section 3.1 below, by reviewing the literature on the notion of policy, on the approaches to policy analysis, contemplating how such analysis is determined by one's understanding of the notion of policy, and elaborating how this locates my approach to the analysis of medical education policy. Towards the end of this chapter, in section 3.2, I set out the sociological theories, philosophies and concepts that form the theoretical framework upon which I base my analysis of UK medical education policy.

3.1 The Literature

Whilst policy is not a function that is restricted to the state, it is one of the most commonly utilised mechanisms by which the state seeks to exercise power, and establish, maintain and extend control, over individuals, groups and organisations in society. In fact, in most states operating on the basis of parliamentary democracies, the state proposes and the opposition opposes and counter-proposes, a number of policies in order to provide solutions to issues they view as problematic. Therefore, the analysis of policy is a crucial means by which the exercise of such power and control by the state can be engaged with, studied and scrutinised.

Policy analysis has a long history, and is performed in a large variety of fashions, following a multitude of traditions, and using an abundance of methods, to the extent that there is no singular consensus means by which it is carried out. In fact, the literature is rife with policy studies conducted following different traditions, methodologies and paradigms (Sykes, 2011). Nevertheless, this multiplicity of approaches to policy analysis are all dependent on the analyst's perspective of the ontology and epistemology of policy. Thus, how one approaches the study of policy, as for the study of any other phenomena, must of necessity begin with an acknowledgement of one's understanding or conception of its nature, and of the essence of the perspectives of policy that one intends to describe and analyse (Nudzor, 2009; Greenbank, 2003).

In general use, the notion of *policy* is used to signify a proposal for certain defined actions, but more often than not it is used to describe specific proposals of the state (Codd, 1988). However, there is no general consensus in the literature on what constitutes policy. In fact, the term takes on a multiplicity of meanings which are dependent on the context in which it is used (Buse, Mays, & Walt, 2005; Page, 2006; Torjman, 2005; Gale, 1999; Hogwood, Gunn, & Archibald, 1984).

In the otherwise sparse medical education literature relating to policy studies, the common perspective of policy is one which implicitly ascribes to it the totality of the measures or proposals imposed upon a particular social domain. For instance, the use of the term *health policy* signifies a collection of specific measures and proposals dealing with the domains of health (Buse et al., 2005; Moran, 2006). For instance, Patel, Davis, and Lypson (2011) argue for the inclusion of health policy in medical education in order to produce doctors that are aware of the importance of such policy, and to keep these doctors abreast of health service changes. They treat the notion of policy as non-contentious, and do not actually study health policy but merely advocate its explicit inclusion in medical curricula. Literature such as this adds nothing useful to the understanding of what policy is in essence, but merely serves the purpose of classification and nomenclature.

Even literature that is aimed at the next generation of policy analysts similarly lacks consensus on the essence of policy. Hogwood et al. (1984), for instance, describe it as either a) a generic expression of purpose, b) a label for a field of activity, c) a specific proposal, d) a formal authorisation, e) a specific programme, f) an output of government activity, g) an achievable outcome, h) a governmental decision,

i) a specific theory, or even j) a cyclical process (Hogwood et al., 1984, pp. 13-19). On the other hand, Codd (1988) describes policy as the "official discourse of the state" (Codd, 1988, p. 237). Importantly, in defining policy as such, Codd (1988) overtly amalgamates it with discourse, and simultaneously highlights the inter-relatedness of both concepts in the context of government. Unsurprisingly, by defining policy as discourse, he then advocates the need to study it by the application of discourse theory, the deconstruction of its text, and the use of procedures drawn from discourse analysis.

However, by describing policy as he does, Codd (1988) lamentably delimits its use to the state, and overlooks the fact that it is not a function that is exclusive to the state, but it is one that is formulated, transmitted and implemented by *actors* at all levels of society. Drawing on Buse et al. (2005), I use the term *actors* here to denote those individuals, groups, organisations, and institutions (including the state) that participate in, have an interest in, or have some influence on policy, in spite of the fact that a) it would be impossible to separate individuals from the groups, organisations or institutions that they belong to, and b) it would be misleading and inappropriate to regard groups, organisations as speaking with one voice.

While the state is perhaps the most prolific public user of policy, this by no means suggests that it is the only one. The perspective of policy as a notion that involves authoritative decision making and/or allocation of decisions, proposals and solutions, irrespective of the source of these decisions and allocations, broadens the view of authorship and use of policy beyond the confines of the state. In this perspective, policy is defined in terms of the "authoritative allocations" (Richardson, 2006, p. 4) of particular proposals and solutions, and the values, interests, choices, actions and decisions (Buse et al., 2005; Sykes, 2011) of those in authority, but crucially, also in terms of the inaction of, or the failure to make decisions by those with responsibility over particular social areas (Dye, 2013; Buse et al., 2005). As Buse et al. (2005) eloquently assert this latter point, policy "refers to the decisions *taken or not taken* by those with responsibility for a particular policy area" (Buse et al., 2005, p. 8, emphasis mine). This perspective is further dependent on a particular understanding of the notion of policy as a mechanism for the *discursive exercise of power* (Bourdieu, 1999; Fairclough, 1989; Foucault, 1982). Foucault (1982) argued that the exercise of power through discourse (see section 3.2.1) is not necessarily visible or overt, but is more often than not manifested as *guidance* that produces or justifies that which is

held as knowledge or truth. According to Foucault, the discursive exercise of power is commonly aimed at limiting the possibilities of alternative behaviour, knowledge or thought, narrowing the variety of possible outcomes and (self-)legitimating the aforementioned exercise of power (Foucault, 1982, p. 789). In fact, it is more or less self evident that in the social context, power is generally exercised through the mediums of dialogue, communication, and discourse. Further, the inextricably intertwined nature of the exercise of power and discourse in social interactions of any kind facilitates such insidious application, and implies that there cannot be any discourse that exists entirely free of power relations (Howarth, 2010; Wang, 2006).

Buse et al. (2005) in their treatise on health policy, describe policy as a tool for the exercise of power, both by those formulating, and those implementing policy. The majority of the otherwise sparse medical education literature relating to policy studies is based on this Foucauldian perspective of policy. However, while there is an implicit recognition of the exercise of power through policy, this literature is mainly uncritical in this regard and typically consists of evaluative studies seeking either to provide information useful for policy makers, or to simply challenge specific aspects of the policy. Dogra and Williams (2006), for example, sought to challenge the implementation of cultural diversity in medical school curricula in response to the urging of the GMC in its *Tomorrow's Doctors* (GMC, 2003) policy. Recognising the extent of the policy process, they utilised trajectory studies involving the use of semi-structured interviews of policy actors. Their criticism of the policy however, rests in a large part on what they view as the insufficiency of prescriptive guidance in the *Tomorrow's Doctors* (GMC, 2003) policy. They asserted that the policy was not adequately clear about what the values and intentions of the authors were in the formulation of the policy. In drawing attention to the values and intentions of the authors however, they fall foul of the pitfalls of "intentional fallacy" (Codd, 1988, p. 236), discussed in more detail below, by assuming that the policy text needed to be reflective of the intentions of its authors. Their concern further reveals their understanding of policy as a deterministic undertaking with recipients unable to act outside the intentions of the policy authors.

On the other hand, Bateman, Hibble, and Hand (2000) sought to inform and contribute actively to the formulation of GMC policy in the wake of the publication of *Tomorrow's Doctors* (GMC, 1993), by taking an approach informed by an amalgamation of action research and ethnographic methods. They argued

that such active involvement with policy is necessary to empower those affected by it to engage with it, challenge it, and contribute to its further development. They however, relate uncritically to the formulation of policy by the GMC, except in regard to the aforementioned lack of engagement by policy implementors in the process. Crucially, while both Dogra and Williams (2006) and Bateman et al. (2000) critique the contemporary GMC policies, they do so with the presumption that the actions and intentions of the authors in the formulation of the policy are benevolent and aimed at the good of the recipients. In common with the majority of medical education literature, there is no attempt to challenge this taken-for-granted 'truth'.

In contrast, Boursicot and Roberts (2009), in their evaluation of the apparent resistance to the perceived feminisation of the medical profession, argue that Widening Participation policies in the arena of higher education have had a minimal effect on the medical profession. They argue that the resistance to the feminisation of the profession is derived from misconception of the effects of social inclusion, and an intolerance towards non-traditional applicants to medicine. They approach their study of Widening Participation in medical education with the view that GMC and higher education policies had entrenched the stereotypical 'white male doctor' as the mainstay of the medical profession, and are implicitly sceptical of the ability or intentions of the policy authors to reverse this.

The discursive exercise of power as exemplified by the above however, goes beyond merely providing guidance and limiting alternative thought as exemplified by the work of Dogra and Williams (2006), Bateman et al. (2000) and Boursicot and Roberts (2009) discussed above. It is also manifested in the application of limits or controls on " access to discourse and communicative events" (van Dijk, 1996, p. 85) such as the restriction of opportunities to access and utilise the news media. In a sense, controlling such access and the communicative events themselves confers upon those exercising power the ability to manipulate or control the discourse(s) available to the recipients, to the benefit of those exercising power. As van Dijk argues "the persuasive or manipulatory success of … dominant discourse is partly due to the patterns of access of … text and talk" (van Dijk, 1996, p. 91). In fact, the legal obligations of learners and doctors, the expectations of what constitutes proper professional behaviour particularly in regard to the dominant discourses of *patient confidentiality*, *patient safety*, and *professionalism* in medical education and practice, (HSCIC, 2013; Hilton & Southgate, 2007; Shirley & Padgett, 2006), as

well as the explicit requirements of the GMC (GMC, 2013a), are frequently drawn on to restrict access to social and news media by learners and doctors. In addition, the role of medical educators in controlling educational discourse, or that of doctors in the dominance of medical discourse and, as Foucault (1997) would have put it, their role in manipulating and controlling knowledge and orchestrating the games of truth that validate the patterns of exertion of power, further exemplify the discursive exercise of power in these respective domains.

I would argue therefore, that power is commonly exercised in the discursive sense by putting in place mechanisms that ensure that the preferred discourse of those exercising the power gains prominence, in order to ensure that the goals of those exercising power are preferentially achieved over the goals of those upon whom power is exercised. The major means by which such discursive exercise of power is achieved in modern society is by means of policy (Maguire, Hoskins, Ball, & Braun, 2011). Policy therefore, regardless of how it is viewed and understood, provides a window though which the fluctuant relations of power and discourse inherent in governance and the control of society may be studied. It is in light of this perspective that I have chosen to study UK medical education policy, treating its critical analysis as a means by which I could help to illuminate the mechanisms leveraged thereby a) to advance particular sociopolitical agendas, and b) to demarcate the boundaries within which medical education is permitted to progress and develop.

Regardless of the thrust of the preceding discussion, the challenge of undertaking policy analysis is made more significant by the lack of a consensus understanding of the notion of policy. While the medical education literature is sparse in aspects relating to policy studies, and in a clear perspective of the essence of policy, the fields of sociology, policy studies and critical discourse analysis are much more abundant and helpful in this regard. What the literature from these fields reveal in relation to policy, is that it can be perceived either as a) the artefactual *outcome* of a deliberative process of formulation and transmission of policy (Saarinen, 2008; Ball, 1993; Henry, 1993), b) as the policy *process* itself (Gale, 1999; Codd, 1988), or c) as both the *process and its outcome* (Ball, 2015; Lindblom, 1979, 1959). These distinctions in the way in which policy is perceived are crucial in understanding how policy is subsequently studied.

3.1.1 Policy as outcome

In the 'policy as outcome' perspective, policy is viewed as the tangible or apprehensible product of a process of formulation and reformulation. A product that is often reified in the form of textual documents (Pollock, 2006; Ball, 1993; Henry, 1993). In this perspective, such documents are treated as though they comprised a snapshot of the entirety of the policy process, and that the use of language and the meanings inferred from a reading of the documents accurately reflect those inherent to the policy process.

A significant problem with this perspective is the fact that the textual or documentary outcome itself cannot reliably capture the entirety of the social interactions integral to the policy process. In addition, the creation of a policy document entails a decision making process by the policy maker(s) in regard to what to include and what to exclude from it. As such, policy documents can only reliably be reflective of this decision making process, or of the official preferred record of particular events, and not the entirety of the social interactions preceding the publication of the document. As McCulloch argues "documents … are probably strongest in presenting official viewpoints and those that have ultimately been successful, rather than those of subordinate and oppressed groups" (McCulloch, 2004, p. 37).

It is further presumed, in the policy as outcome perspective, that the discourses embodied in policy documents are in some way indicative of the assumptions, perceptions, meanings, and understandings prevailing at the time at which the documents were created, as well as the values and intentions of the policy actors (Burnham, Lutz, Grant, & Layton-Henry, 2008, p. 250). In addition, it is surmised that the emergence, continuities and discontinuities of the discourses that are embodied in the documents reflect the tensions, conflicts, struggles, and compromises occurring in the compilation of the policy documents (Burnham et al., 2008; Ball, 1990). However, the assumption that policy documents contain within them the intentions of the authors rendered as text exposes one to "intentional fallacy" (Codd, 1988, p. 236), in which the one reading a document incorrectly assumes that the reception, interpretation, implementation or impact of a specific policy is exactly what the authors intended (Pollock, 2006). The issue here is that such a fallacious assumption presupposes that the meanings implied by a basic reading of the text reflect the authors' intentions, and that the text can thus be taken as evidence of these intentions, hence the fallacy. In fact, because there are a multiplicity of meanings and understandings

that can be discerned from any document, it is impossible to determine which of those are an accurate representation of the authors' intentions. Further, there is a key distinction between what is intended on one hand, and statements of intention on the other. Thus a statement of intention may not necessarily express the author's (or speaker's) real intentions, and in fact, the author may even be *mistaken* about his/her own intentions (Codd, 1988, p. 239). Further, holding to the view that documents are snapshots that capture in some way the culmination, and indeed the end, of the policy process and preserve the intentions of the authors, does away completely with the recognition of the process as a dynamic cyclical progression that does not necessarily cease with the mere publication of a policy document.

Coming from the "technical-empiricist" (Codd, 1988, p. 237) persuasion, my own position is that policy documents may indeed contain the textual expression of intentions, values and meanings. However, whether or not these are the policy maker's, or in some way accurately representative of the policy maker's *real intentions*, *values* and *meanings* is impossible to determine with any certainty, particularly in view of the tendency of authors to portray themselves or their role favourably in the creation of documents (McCulloch, 2004, p. 33). Likewise, how those intentions and meanings presented in documentary form are received and interpreted may not therefore accurately represent either the author's original intentions or the written statements of intention. The key understanding here is that language in policy is typically used in both a contextual and a referential sense, and does not *ipso facto* carry or convey fixed, universally understood meanings.

The limitation of the policy-as-outcome view therefore, is that it carries within it the unfortunate assumption that policies are finished products once published, that the process before and after publication is inconsequential to the finished product, and that the process and product are mutually exclusive.

It is however feasible to study the discourse within policy documents in order to gain an understanding of the assumptions, perceptions, and meanings *conveyed* by the policy. Indeed the conceptual links between discourse on the one hand, and social structure, relationships and processes on the other, are important for the exploration of policy documents and justify drawing on discourse theories in the analysis of policy (Taylor, Rizvi, Lingard, & Henry, 1997). Without unequivocally giving credence to the policy as outcome view, this thesis draws on the documentary study of policy, and specifically on the

critical analysis of discourse in policy (and policy as discourse), as a means of laying bare the significance, thrust and implications of UK medical education policy as these are articulated in the construction of policy problems.

3.1.2 Policy as process

In contrast, the policy-as-process perspective views policy as processual, cyclical and yet disordered, incremental and inexact. It perceives the policy process as occurring at all levels of society, namely: the macro-level, where it is concerned with global or international issues, influences and policies, at the meso-level with the local or national agenda, structure and issues, and at the micro-level where it operates at the level of delivery and implementation (Hudson & Lowe, 2004). This perspective of policy derives from the foregrounding of the policy cycle in policy studies; a cycle which is marked by the continual tweaking, spinning and modification at each stage (if these stages can even be discretely identified) of its formulation, implementation, evaluation and re-formulation (Parsons, 2002; Ball, 1993; Lindblom, 1979, 1959). In this cycle, policy actors are perpetually involved in a chaotic yet cyclical process of "building out from the current situation, step-by-step and by small degrees" (Lindblom, 1959, p. 81). Policy as a process is thus inherently messy, unstructured, "muddled" (Lindblom, 1979, 1959), "ethereal ... diffuse, haphazard and somewhat volatile" (Lomas, 2000, p. 140), and bears little, if any, resemblance to the logical linear and highly structured progression that is depicted in the discrete phases of problem identification, agenda formation, decision making and implementation into which the policy cycle is usually divided for the purposes of description (Buse et al., 2005; Hudson & Lowe, 2004).

Supporting the perspective of policy as a process, Jenny Ozga argues for instance, that policy is a process that is "struggled over, *not delivered, in tablets of stone*" (Ozga, 2000, p. 1, emphasis mine). She contends that policy consists of an intangible and ethereal realm of contest, confrontation and negotiation between individuals and groups, and not necessarily in the tangible product of such a process. This chaotic process that she describes is a manifestation of the tensions, compromises and conflicting power relations that are reflected in the conflict, struggle, the rise to, and the fall from dominance of competing discourses in policy (Ozga, 2000; Taylor et al., 1997). It is this relationship between the process itself,

and the role that power relations play in the process, that is crucial to understanding policy as process. The benefit of this approach is that it highlights the roles and identities of individuals and groups in the formulation of policy, and foregrounds the hegemony and the exercise of power inherent in the process.

The challenge posed by holding to the policy as process perspective, is that it presents policy as a constantly moving target, and thus one which does not lend itself to analysis of static stages or outcomes. In fact, an analytical focus on policy as a process may inadvertently result in a focus on policy actors and their interactions, rather than the process itself. The other difficulty with holding onto this view is that in public policy making, the vast majority of the process is hidden from public view, and occurs in situations from which the public, and researchers, are prevented from accessing. It is illusory therefore to presume to have access to the entire policy process for the purposes of study and analysis.

Beneficially, the reification of the previously mentioned chaotic process in discourse warrants the application of discourse theories to policy analysis. However, in contrast to the policy as outcome view, this perspective does not give much heed to the preservation and embodiment of discourse in policy documents, or the use of documents as a source of primary data, except in regard to use of triangulation in policy studies. Thus, in this perspective, even though the most accessible aspects of the policy process are often the published outcome, the outcome is viewed as though it were inconsequential to study on its own merits. In my view however, while the policy as process perspective definitely has its merits, it presents to the researcher a constantly moving target that means any analysis can only be performed on a snapshot of the process and thus invariably suffers from a lack of comprehensiveness. Any attempt to study the process must itself be subject to constant modification and remodification in response to the dynamic nature of the object of analysis. In this thesis therefore, I take the more inclusive view of policy as *both* process and outcome as I discuss briefly below.

3.1.3 Policy as *both* process and outcome

The shortcomings of the policy-as-outcome and policy-as-process views are both mitigated, and their benefits made accessible, by adherence to a perspective of policy as *both* a process and an outcome

(Nudzor, 2009). Supporting this perspective, Nudzor argues that policy is both "that which is made and set intentionally to rectify an issue of concern" as well as that "which is enacted and/or struggled over within the policy terrain" (Nudzor, 2009, p. 93). In this perspective, policy is both an ideologically informed intangible, messy, inconstant, discursive *process* that shapes and is influenced by society and the prevailing social environment (Lindblom, 1979, 1959), and whose tangible, discrete *outcome* is often concretised as text and discourse (Gale, 1999; Ball, 1993).

The benefit of this perspective is that it foregrounds the struggle, contestation and negotitation that occurs in the policy process, but unlike the policy as process view, it regards the published policy as a mere snapshot of an ongoing undertaking, and not the culmination or summation of the process. Crucially, it does not disregard the significance of the published policy in shedding light on the preceding cycle interactions, rather, it provides the ability to consider the outcome in light of the ongoing process. Studying the published policy thus sheds light on aspects of the process from which it was derived, the ideologies that preceded, drove and influenced it, and helps to predict and chart the way forwards in the ongoing policy process. It is this perspective of policy as both outcome and process that is most closely aligned to my comprehension of the notion of policy, and thus the perspective that underpins my analytical approach in this thesis

What is clear from this short synopsis of the engagement of the literature with a definition of policy however, is that one's perception of the notion of policy determines how it is engaged with, studied, analysed and interpreted, and thus what significance is ascribed to any research findings (Nudzor, 2009; Ball, 1993). One pertinent question remains unanswered however, namely is UK medical education policy any different from other policies, and where does it fit in the spectrum of policies?

UK medical education policy

UK medical education policy is no different from any other policy and can thus be viewed as a *process*, as an *outcome* or as a *process* that is reified in a published *outcome* as the legislation, rules, regulations, guidance, stipulations or directions for medical education, but also includes all the processes within

and without the GMC leading up to, and ensuing from its formulation (Taylor et al., 1997; Ball, 1993). Medical education policy is not made in a vacuum nor is it possible to exclude other policy and non-policy influences on the policy process. Indeed, drawing on the work of Gale (2007) and Ball (1993), medical education policy will arise as the result of challenges to social norms and values, is formulated as the result of various contestations and compromises, and received, translated and implemented at all levels in the light of other policies, values and norms. Thus any policy formulated to deal with medical education issues will by definition draw on and/ be influenced by related policies including those covering health and higher education. Importantly, medical education policy is also a mechanism for the transmission and exchange of values: the values of the state, the GMC, and those of special interest groups and stakeholders with which the state reaches compromises, contextualised and passed on to all those involved in medical education, and values of medical educators modifying the implementation of policy and being reciprocally passed up the chain to policy makers (Gale, 2007; Gewirtz, Dickson, & Power, 2007; Shattock, 2006; Prunty, 1985).

By means of its policies however, the GMC has effectively dragged control of medical education away from the "influences of the medical school and teaching hospital" (Rees & Jolly, 1998, p. 255), towards the community and the public at large. This has put it squarely into the realm of compromise and negotiation between public and community health policy on the one hand, and higher education policy on the other, particularly in view of the fact that modern UK medical education is aimed at producing a new doctor to function in a rapidly changing health system (Towle, 1998).

The reception of the GMC's policy by medical schools and educators has not been without significant distress however. In fact, the medical education literature is rife with disparaging discussion reflecting on the challenges of the implementation of the policy and its impact. The perceived impact of the policy on the place and prominence of particular subjects in the curriculum (Crilly et al., 2009; Cottrell, 1999; Monkhouse & Farrell, 1999; Singh, Baxter, Standen, & Duggan, 1996), the inclusion of policy issues in the curriculum (Patel et al., 2011; Dogra & Williams, 2006), and on the detailed curricular content (Coldicott, Pope, & Roberts, 2003; Maxwell & Walley, 2003; Cormac, Cottrell, Fleminger, & Katona, 1997) are the most hotly contested issues in the literature – probably as a result of the direct lived effects these had on the activities and perceptions of educators. Also prominent in the literature is discussion of the impact

of the policies on selection of medical students (Steele, 2011; Stephenson & Stephenson, 2010; Powis, Hamilton, & Gordon, 2004), the emphasis here being put on the lack of prescriptive guidance from the GMC about this aspect of medical education. However, what is most notable about medical education policy studies is that they are almost universally concerned about micro-level policy issues.

In contrast, the literature is incredibly silent on the subject of medical education policy at the meso-level as though it were viewed as subservient to, and therefore less important to study than the more laudable national policy issues concerning health, higher education and the regulation of medical practice. In fact those that bother to consider medical education policy treat it as if it were solely a subset of either higher education policy (Bourke, 1997) or health policy (Wennström, 1980) and not as a discrete entity related to both fields. There is for instance, a small body of literature dealing with more generic aspects of health policy that carries implications for medical education, such as the the contributory role of medical professionals to the formulation of policy (Flitcroft, Gillespie, Salkeld, Carter, & Trevena, 2011; Bateman et al., 2000), and the struggle for dominance in the policy process between the medical profession and the GMC (Salter, 2007). There thus appears to be a preoccupation in the medical education literature with micro-level policy issues and little or no attempt to engage with the meso-level policy issues (Ball, 1993; Ozga, 1990).

Even with this minimal involvement, there is little attempt in the medical education literature to critically engage with or analyse the policy itself (Bleakley et al., 2011; Musick, 1998). Park (2012), who is one of a small minority of authors to critically engage with *Tomorrow's Doctors* (GMC, 2009) at the meso-level, asserts the importance of such analysis to medical educators, and discusses the significance of the inculcation of the ideologies of policy makers into the policy. This paucity in the literature is not, *ipso facto*, a sign of lack of awareness of its importance to educators however. Bleakley et al. (2011, p. 255) argued, for instance, that mutual critical dialogue between policy makers and medical educators is essential to make policy relevant to educators, and to permit educators to contribute to policy. In like manner, Musick (1998) asserted the importance of an understanding of policy analysis to the facilitation of decision making in medical education. There is therefore a salient gap in the literature insofar as the critical analysis of policy from a medical education perspective is concerned.

Straddling this gap on critical medical education policy analysis is a significant literature on new and changing discourses in medical education, such as that of the "good doctor" (Whitehead, Hodges, & Austin, 2013; Hurwitz & Vass, 2002; Huxham, Lipton, Hamilton, & Chant, 1989) and that of "competence" (Hodges, 2012; Lingard, 2009; Rees & Jolly, 1998; Rethans, van Leeuwen, Drop, van der Vleuten, & Sturmans, 1990), which both precede, and are contemporary to, the development of UK medical education policy. This temporal–contextual link, and the fact that these discourses are currently in common usage both in public and in medical education suggest a significant discursive influence on the policy. In fact Hodges (2012) shows how the contemporary discourses of knowledge, performance, psychometrics, reflection and production in medical education have interacted with, influenced, and been influenced by the discourse of competence.

This thesis is aimed at contributing to filling the aforementioned gap in the literature by critically analysing UK medical education policy at the meso-level. In view of the cross-discipline nature of policy analysis and the lack of analytical tools exclusive to medical education, I will draw on the extensive analytical tool-chest in the social sciences policy analysis fields to facilitate my analysis. Crucially, my approach to UK medical education policy analysis makes the justifiable assumption there is nothing that would make medical education policy fundamentally unique in any way that could set it apart from other educational or public policy (Gale, 2007). Medical education policy like any other educational policy simply provides a scaffold upon which educational activities must be carried out, or a framework that dictates what can be done, and when, where and how that which must be done can be done (Lingard & Ozga, 2007; Ball, 1993).

The abundance of literature on public policy in general, for education, for higher education, and for health – areas with which medical education has a close relationship – make it possible to get some insight into public policy and how it applies to these related fields, and extrapolate these findings into the field of medical education in order to identify similarities and differences, and thus facilitate the formation of a framework upon which medical education policy can be analysed (Musick, 1998). While I will draw on a broad literature from these areas in order to elaborate and explain what may be going on in UK medical education policy, I approach it from the post-Saussurean perspective where meaning is conceived as an inconstant notion; one that is intimately dependent on the sociopolitical context of its construction and

use, to the extent that some specific meanings may, transiently at least, rise in importance even to the point of attaining the standing of self-evident truth (Barker & Galasiński, 2001). As such, the analytical work in this thesis, as I discuss further in the section 3.1.4.2, is based on the assumption of the mutability of meanings, and that there may be a dissonance between the meanings communicated in the wording of policy and those that may be interpreted from its reading.

3.1.4 Analysing policy

As I have asserted above, the approach taken in any analysis of policy is largely determined by one's understanding of the concept and purpose of policy, and whether it is an analysis *of* or *for* policy (Gordon, Lewis, & Young, 1997).

Traditional approaches to policy analysis derive primarily from the positivist-objectivist understanding of what policy is, and how it can be studied. In fact, a search of the literature reveals that the predominant approach to policy analysis is based on a positivist-objectivist or technical-empiricist epistemology. Whilst this is the predominant approach to policy studies, it is certainly not the only one. Some of the more recent and prominent alternatives to this approach include those based on interpretivist, postmodern or social constructionist epistemologies. However, there is a reticence in the literature to acknowledge the utility and validity of these more recent approaches to policy analysis (Bacchi & Bonham, 2014; Bacchi, 2009, 2000; DeLeon & Martell, 2006; Durning, 1999; Lynn, 1999; Coplin & O'Leary, 1987).

3.1.4.1 Traditional approaches

Traditional approaches to policy analysis make the assumption that both the formulation of policy and its analysis is value-free (Greenbank, 2003). They stand on the premise that there is, out there somewhere, a tangible, apprehensible reality that can be accessed objectively and without influencing it. They further assume that this reality is amenable to study, and yields the same inviolable truths to any and all who so choose to study it. In this approach therefore, the analysis is undertaken with the view that the

'tangible reality' of the policy in question is unchanging, and that the analyst has the means of objectively assessing the thrust, implications and effects of the policy, without influencing the analysis with his/her own values and perspectives, or being reciprocally influenced.

Traditional policy analytical studies are typically performed either a) in advance of the formulation of policy, in order to provide information or 'evidence' to the policy makers in order to inform decision making (Yanow, 2000), or b) after the fact where they are typically performed for the purposes of impact assessment, cost-benefit examination, philosophical or political implications, , or to provide evaluative information to those with particular interest in it, such as policy makers, politicians, stakeholders, researchers and implementers (Winship, 2006; Yanow, 2000). Further, they tend to rely on the positivist mainstay of quantitative approaches, utilising numerical and statistical methods as a means of conceptually disaffiliating the analyst from any personal interest in the policy, and thus represent the analysis as objective, unbiased and value-free. Even more importantly however, such policy analysis is quite often aimed at providing the justification for particular modes of power exercise, or providing the evidence for desired policy interventions (Wilson, 2006). The *task* of such policy analysis is thus generally one of monitoring and determining the merits of policy interventions, or evaluating their efficiency or cost-benefit relationship, and on the quantification, 'objective' comparison, applicability, and generalisability of policy (Vedung, 2006; Vining & Weimer, 2006),

These traditional approaches are thus rooted in two fundamental, yet in my view, fallacious premises. Firstly, that there is a discrete, identifiable and absolute 'best outcome' for the good of society, and that the analyst has the ability to determine what would be the best course of action to achieve the greater good (Munger, 2000, p. xi). Secondly, that the analyst knows the 'truth' about the policy maker's intentions, that these intentions and the aims of policy-making are for the greater good of society, and that the analyst can demonstrate how these reflect the essence of the "social good" (Winship, 2006, p. 110).

However, approaching policy analysis from this perspective amount to cutting the proverbial Gordian knot to get at the outcome by the simplest means possible without seeking an understanding of the "knotty problems of policy" (Munger, 2000, p. 5). As Winship (2006) argues, traditional policy analysis is

akin to completing a jigsaw puzzle - a process of attempting to harmonise apparently contradictory policy ends. In arguing so, he perhaps inadvertently reveals the 'Achilles heel' of the traditionalist approach to policy analysis in that it implies the existence of a single 'correct' solution - the optimally completed jigsaw - and thus the objectively demonstrable 'truth' of the policy. Further, this approach erroneously views the analyst as an objective and impartial observer of an otherwise value-free process.

3.1.4.2 Interpretive approaches

In contrast, the interpretive approaches to policy analysis draw on the epistemology and ontology of philosophies such as "phenomenology, hermeneutics, and (some) critical theory from Continental Europe and symbolic interactionism, pragmatism, and ethnomethodology from the US" (Yanow, 2007a, p. 110). These approaches place emphasis on social realities, meanings and interpretations (Yanow, 2007a, 2000), welcome the influence of the analyst, and do not attempt to depersonalise or de-value the process or its outcome. The focus of the interpretive approaches to policy analysis is the study of the meanings, as opposed to the facts, as they are transmitted in policies, and emphasis is put on how these meanings shape the actions, identities and subjectivities of individuals, groups and organisations (Wagenaar, 2011).

The interpretive approaches do not consider meaning as existing in the published policy document but rather assume that every aspect of policy, including published texts and the social interactions of policy actors, are imbued with meaning. In fact, to the interpretive analyst, the impact and implementation of a policy is dependent on how the policy is received, interpreted and understood. For instance, Van Melle et al. (2014), in their study of the role of education scholarship by medical educators in the transformation of medical education, argue that the ambiguousness of the concept of 'educational scholarship', and the multiplicity of meanings it carries and conveys, lead to a significant difficulty for individuals to understand how they may utilise it in the development of their academic careers. They conclude that it is necessary to create a "common definition" (Van Melle et al., 2014, p. 1198), and thus a consensus understanding, of the concept in order to increase its perceived value to both individuals and institutions in career development. While they explicitly utilise an interpretive methodology in their

work, their argument draws on the fallacious realist view that it is somehow possible to imbue policy, or parts thereof, with singular immutable meanings, and for such meaning to be received and understood unchanged by those reading and implementing the policy.

However, a bonafide interpretive approach is dependent on the point of view that there is no singular 'true' meaning transmitted by policy, but rather a multiplicity of inconstant meanings and equally innumerable understandings and interpretations of these meanings – hence the need to place the emphasis of study on the significance of these meanings (Yanow, 2007b; Barker & Galasiński, 2001). In these approaches, there is thus no single correct reading of a policy or infallible interpretation, but rather "multiple, apprehendable, and equally valid realities" (Ponterotto, 2005, p. 129). In fact, as Yanow argues in relation to the role that hermeneutics plays in interpretive policy analysis:

> " people imbue the artifacts they create with meaning and/or project meanings onto those artifacts (or read meaning out of them) as they engage them. In the course of engagement, the artifacts' underlying meanings are re-instantiated and maintained - or changed, as artifacts and their meanings are reinterpreted" (Yanow, 2007a, p. 114)

The values, intentions and interests of policy makers permeate and influence policy in its formulation. Reciprocally, each reading of a policy is in turn influenced, permeated and shaped by the reader's own values, interests and approaches. The interpretive approach thus presumes that the meanings borne by a policy, and those derived from its reading, are irregular, variable and amenable to the influence of both the authors and those that analyse it. For instance, the notion of disability is defined within the Equality Act 2010 as follows:

> "A person (P) has a disability if –
> (a) P has a physical or mental impairment, and
> (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities."

Disability policies developed on the basis of this legislation can either be interpreted and implemented according to this *medical model*, or along the lines of the *social model* where disability is a social construct (Roulstone, 2014). In either case, the issue for the interpretive policy analyst are the differences between

the intended and the received meanings of a policy (Yanow, 2000). As such, the interpretive view of policy is such that it can only be comprehended by *subjective* intervention and interpretation – the author, recipient and researcher all interacting subjectively with the policy.

3.1.4.3 Argumentative approaches

The argumentative approaches to policy analysis reject the tenets of logical positivism, objectivism, instrumentalism and rationality exemplified by traditional approaches, and draw on interpretive means to systematically access, interpret and analyse policy. The epistemology of these approaches is such that policy and its analysis are regarded as value-laden communicative social practices which are thus amenable to the study of argumentation. Utilising these approaches, analysts undertake the analysis of policy with the presumption that language and its use are fundamental to the formulation, interpretation and understanding of policy (Gottweis, 2006; Dryzek, 1993).

These approaches draw from the understanding of policy as a messy unstructured and virtually unpredictable social undertaking (Lindblom, 1979, 1959), but an undertaking that requires an understanding of the use of language, semantics and discourse in order to reveal the multitudinous interpretations possible. Importantly, they recognise policy as a mechanism for the persuasion of society by reasoning, justification and argumentation (Dryzek, 1993), and its analysis as potentially yielding discordant interpretations and fragmentary narratives. These approaches further focus on aspects of subjective interpretation and understanding, problem construction and critical evaluation of policy (Gottweis & Fischer, 2012; Fischer & Forester, 1993)

While they are all lumped into this single classification, there is no major coherence between the argumentative approaches to policy analysis. In fact, there are significant differences in epistemology, however, a major portion of these approaches draw on the recognition of the primacy of discourse to policy. There is a distinction for instance, as Fairclough (2013) argues, between the approaches based on post-structuralist discourse theory, cultural political economy and critical discourse analysis. He further argues that the fundamental distinction between these approaches is based on the fact that the

former two are political or political-economic theories while the latter is a “theory of and methodology for analysis of discourse” (Fairclough, 2013, p. 178). It is however beyond the scope of this chapter to delve into the intricacies and eccentricities of each individual method, methodology or theory, beyond providing a coherent justification of my approach to policy. I will therefore consider the post-structuralist approaches to policy studies, a key underpinning of my approach in more detail in the next section.

3.1.4.4 Post-structural approaches

Post-structuralist policy analysis is an eclectic articulation of the post-positivist critique of the positivist-structuralist assumptions that were the foundation of traditional policy studies (Gottweis, 2003), and a collection of approaches that represent the use of language and discourse as fundamental to the analysis of policy. They share with the interpretive and argumentative approaches the focus on meanings and their role in the shaping of the actions and identities of individuals, groups and institutions. To the post-structuralist, words do not have a singular invariable meaning, but carry such subjective significance as is determined by use, context, reading and interpretation. It is this fluidity of meaning that marks the main point of departure of post-structuralist approaches from those based on Saussurian structuralism. Even more important in this view is the perspective that language which appears transparent in use, may in fact obscure insidious and subversive strategies, because such transparency may be derived from the calculated use of discourse that renders some things more clear than others in special circumstances (Lather, 1996). Language in the post-structuralist sense is therefore not considered as a dispassionate means for the transfer or sharing of meaning, nor is it considered a mechanism by which inviolable truths of a reality ‘out there’ may be communicated, but rather a mechanism for the sharing of contested and contestable meanings, ideas and interpretations.

The post-structuralist approaches draw on a common ground with those based on critical theory, in which they aim to demonstrate the elevation and privileging on the one hand, and the marginalisation and deprecation on the other hand, of individuals and groups by means of policy (Walker, 2009). These approaches recognise the omnipresence of power and the centrality of its exercise in social relationships

of all kinds, and as these are expressed in policy in particular. Foucault, for instance, described power as omnipresent at every level of social interaction:

> " not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere." (Foucault, 1979, p. 93)

This power is exercised in a social arena that is not a singular unified entity, but is composed of multiple, multifaceted overlapping, interrelated, intersecting and interacting "sociospatial networks" (Mann, 1986, p. 1).

Even though the exercise of power is omnipresent, it is also omnidirectional, inequitable and asymmetrical, and therefore always results in the domination by *dominant* social entities over others that are *dominated* (Foucault, 1997; van Dijk, 1996). The post-structuralist perspective is therefore crucially concerned, as Howarth and Griggs argue, with the "ways in which meanings are created and contested by rival political forces in particular policy settings, and how these settings are related to wider social systems and power relations" (Howarth & Griggs, 2012, p. 306). From this perspective therefore, policy is an instrument of the social exercise of power and control, or a mechanism for domination of one individual or group by another (Goodin, Rein, & Moran, 2006). To say however, that one exercises power over another is not to say that the one exercising the power in that context necessarily has an advantage over the one upon whom the power is exercised (Haworth, 2006). It is simply the case that the policy maker seeks, explicitly or implicitly, to exercise power by foregrounding particular discourses and suppressing others, in order to privilege particular courses of action in individuals or groups. As such, policy in the post-structuralist sense is also a means of determining what can and cannot be done in a particular context (Bell & Stevenson, 2006), and a conceptualisation of the means of validating, endorsing and privileging the expression of particular ideas and values (Colebatch, 2006). These approaches thus shift the attention of the post-structuralist analyst "away from what is said and done, towards the importance of how something is said, how it is interpreted and how it is mobilised" (Walker, 2009, p. 91). However, the focus is placed not just on the use of language, but on discourse, on the discursive

effects of policies, and on how discourse produced or privileged by the policy maker creates subjects and subjectivities.

Whilst there have been, and still are, several contributions in the literature to post-structuralist policy studies, Bacchi's (2016, 2015, 2012, 2010, 2009, 2000) work has been particularly persuasive and influential in demonstrating the purchase that can be obtained in the analysis of policy as problematisation by the study of problematisation in policy, and showing how this can be used to illuminate the hegemony and unfair exercise of power inherent in policy.

Despite drawing on the post-structuralist perspective however, Bacchi (2000) argues that policy, rather than *being* a *form* of discourse, describes the *use* of discursive means to represent problems in such a fashion as to insidiously suggest that particular remedies are the only logical and self-evident solution to the problems. It is this post-structural/social constructionist (Burr, 2003) position on policy as problematisation that locates this thesis, and underpins the analytical approach I have employed herein. I will therefore explore it in more depth below.

There are however three salient issues that Bacchi's (2000) argument raises. Firstly, Bacchi contends that there is a flawed assumption that there exists, in policy making, a preceding process of discovering pre-existing problems for which policy is then made (2000, p. 48). Policy problems are viewed in this social constructionist perspective as being discursively constructed within the policy itself, rather than real, tangible or in anyway independent of discourse. As Yeatman also argued

> "Social policies, it becomes clear, are not responses to social problems already formed and 'out there'. Social policies constitute the problems to which they seem to be responses. They are involved in problem-setting, the setting of agendas" (Yeatman, 1990, p. 158)

To the social constructionist therefore, policy is formulated to construct both the policy problems and the relevant policy solutions (Bacchi, 2000, p. 48).

In contrast, the traditional, functionalist and comprehensive–rationalist view of policy making is that social problems exist in reality, that this existence can be demonstrated empirically, and thus the problems are available to be remedied by the solutions for which specific policies are then formulated

(Goodwin, 1996, p. 67). In the functionalist view, policy is only created in response to *real* and existing societal predicaments and provides tangible and practical solutions which if followed will lead to resolution of the problems.

While it could be argued that all problems are constructed in the same sense that society is a social construction, it is useful to make a clear distinction as Bacchi argues, between "policy problems" which are those as constructed by policy, and "social problems" which are external to the policy process in some way (Bacchi, 1999, p. 50). Nevertheless, the question of whether or not problems pre-exist, or exist outside the policy process may be contentious, but in my view it is technically irrelevant and peripheral to the policy-as-discourse debate. To illustrate my argument I will take for an example the UK policy aimed at reducing poverty and improving social justice (Department for Work and Pensions [DWP], 2013). There is no doubt that a proportion of society has always, since time immemorial, been unable to afford the basic necessities of life and therefore subject to a state of poverty. *Poverty* could thus be classed in this historical and functionalist view as a pre-existing social predicament for which the aforementioned policy is aimed at alleviating. The same UK policy (DWP, 2013) constructs *poverty* as the lower extreme of the comparison of national household incomes, and an issue of employment or lack thereof, and posits the solution to this as a change in the course of life of those affected by it. This, in keeping with the social constructionist view, the policy in effect disregards the social problem of poverty, and re-constructs it as an issue of lack of employment – thus representing the discursive creation in policy making of the problem of *poverty*.

The crucial distinction therefore, between the social constructionist and the fundamentalist views is simply that the latter views policy problems as discrete, tangible, objective pre-existing realities, while the former views policy problems as mere discursive creations that do not necessarily precede the construction of policy. Drawing from the example I have given above, this does not in any way change what poverty is but merely affects how it is perceived, what meaning it is ascribed in the socio-political context, what remedies are proposed in the policy, and how these remedies construct the identities and subjectivities of those concerned. Besides the semantics of problem pre-existence or construction, there is no further significant difference between the social constructionist and fundamentalist views insofar as the discursive properties of policy are concerned.

The second issue that Bacchi (2000) raises, indeed contingent on the first, is that policy is a mechanism of state (or policy maker) exercise of power, control and domination. She draws on the work of Foucault to describe policy as producing or justifying that which is held as knowledge or truth, and aimed at limiting the possibilities of alternative behaviour, knowledge or thought, narrowing the variety of possible outcomes and (self-)legitimating the aforementioned exercise of power (Foucault, 1982, p. 789). This view to which I also subscribe, also conceives policy as a mechanism for the establishment of *doxa* in society; where individuals and groups are willing to accept certain things as true in ignorance of, or in spite of the 'facts' (Bourdieu & Eagleton, 1992, p. 114). In Bacchi's (2000) view, policy is further manifested in the control, by the state, of access to the media and other communicative avenues. In a sense, controlling such access and the communicative events themselves, confers upon the state the ability to manipulate or control the discourse(s) available to the recipients to their (the state's) own benefit. As van Dijk argues "the persuasive or manipulatory success of … dominant discourse is partly due to the patterns of access of … text and talk" (van Dijk, 1996, p. 91). The role of doctors in controlling medical discourse and their role in manipulating knowledge and orchestrating the games of truth that validate the patterns of exercise of power, exemplify the discursive exercise of power (Foucault, 1997).

Since there cannot be any discourse that exists entirely free of power relations (Howarth, 2010; Wang, 2006), this is an important means by which the policy maker is able to exercise power (Bourdieu, 1999; Fairclough, 1989; Foucault, 1982). Policy is used to put in place mechanisms that ensure that the preferred discourse of those exercising power gains prominence in order to ensure that their goals are preferentially achieved over those upon whom power is exercised (Maguire et al., 2011; Mann & Haugaard, 2011; Howarth, 2010). In fact, policy can be viewed as an attempt by the state to strategically utilise discourse to generate support for, or justify, particular courses of action.

Thus, by constructing particular issues as policy problems, and simultaneously yet insidiously delimiting the number and scope of social issues that make the policy agenda, the state constructs any issues not on the agenda as non-issues. These non-issues are then hidden in plain sight and do not receive any remedy or attention from the state. Policy is further utilised to circumscribe the solutions to policy problems that are constructed within the policy, and to thus discursively establish the theoretical and the practical limits of the response(s) of the policy recipients – limiting their responses to those expressly permitted

by the confines of the policy. It is thus an important discursive mechanism for the exercise of power, and the formulation, transmission and promotion of the political purposes of the state (Maguire et al., 2011; Mann & Haugaard, 2011).

What is important therefore in this schema is the policy maker's perspective on particular social issues, whether these exist independently or not, and the impression thus given to the public that the policy maker is concerned with ensuring social well-being. As Codd eloquently argues "policies produced by and for the state are obvious instances in which language serves a political purpose, constructing particular meanings and signs that work to mask social conflict and foster commitment to the notion of a universal public interest" (Codd, 1988, p. 237). Policy therefore provides a window though which the fluctuant relations of power and discourse that exist in society may be studied.

Thirdly, Bacchi (2000) in her assertion that policy merely *uses* discourse, would seem to suggest that policy and discourse are mutually exclusive concepts, and that discourse is merely a mechanism rather than an integral part of policy. She argues that there is an unfortunate tension between those who focus on the use of discourse, and those whose focus is on the effects of discourse in policy, and that this tension arises from who is seen as holding and wielding power, and those seen as being impacted by power (Bacchi, 2000, p. 51). I would argue that it is indeed the policy makers themselves that *use* discourse to formulate policy in order to achieve their policy aims (MacLure, 2003). In fact, without discourse there would indeed be no policy, and as I have already asserted above, the only distinction between policy and discourse is that policy is a subset, to use a quantitative term, of discourse.

Bacchi (2000) further concludes that there is significant political purchase to be gained by viewing policy as discourse. I concur with this view and see no problem in holding the opinion that discourse is used by dominant actors in their effort to remain dominant. I am cognisant of the fact however, that power and dominance change hands, as discourses ebb and flow between dominance and obscurity (Howarth, 2010). As such I view dominance of a particular actor as a concept that must be discretely defined in temporal and contextual terms (Howarth, 2010). It would be less than rigorous, I would argue, to view any discursive practices or characteristics as being dominant or wielding power without simultaneously defining the temporal and sociopolitical context of the discourse.

Overall therefore, it is the post-structural, and indeed the social constructionist perspective that seems to best describe the landscape of policy as I see it unfold in my own experience.

In light of the discussion above and drawing on Bacchi (2000), I will hereafter focus on policy as a discursive expression of problems and solutions by policy makers and those that influence them; an expression that may be used to legitimise the exercise and application of power over the recipients of policy, by the careful selection and placement of phrases with "divergent meanings, contradictions and structured omissions" (Codd, 1988, p. 235), which are targeted at producing sought-for effects in the recipients of policy; and an expression which is subject to influence, is influenced by, and one that influences situational, structural, cultural and exogenous factors in the wider policy context (Buse et al., 2005; Bacchi, 2000; Cameron, Frazer, Harvey, Rampton, & Richardson, 1999; Gale, 1999; Ball, 1993; Henry, 1993).

My approach to policy as discourse is not concerned with mere descriptive linguistics, or with the rules of language construction in the mediation of social relationships, but rather focuses on discursive statements, what caused them to emerge, how they are modified and maintained, how they are related to other events; and on the power exercise, rules and structures which formulate, modify and maintain them. Having already established above that policy is dependent on discourse for its development and elaboration, I now turn my attention to an aspect of critical policy studies that concerns itself with problematisation in the analysis of policy (Bacchi, 2012; Bacchi, 2009; Bacchi, 2000).

As discussed in section 3.1.4.4 above, Bacchi (2015, 2012, 2009, 2000) challenges the widely held assumption that policies are made in response to pre-existing problems out there, and argues that they are formulated with the twofold purpose of creating novel 'problems' and corresponding solutions. In doing this, she is careful to emphasise that she is only changing the focus of policy analysis from one where policies are viewed as *problem solving* activities, to one where they are viewed as *problematising* activities. It is this 'Bacchian' perspective that underpins the analytical approach to policy in this thesis. The Bacchian approach does not negate or seek to obfuscate the presence of bothersome conditions in society that need rectification but rather shines the spotlight on activities of policy makers and the processes by which policy is made.

Drawing therefore on the key question in Bacchi's approach to policy analysis, namely "What's the problem represented to be? (WPR)" (Bacchi, 2015). I have derived the following overarching research question: **What is the problem represented to be in UK medical education policy?** This research question directs the focus of the analysis on to the discursive representation of problems and the articulation of solutions in the UK medical education policy. I find that a focus on problematisation and the use of the WPR approach thus creates the intellectual space for analysis and critique of policies and policy making, and is therefore the approach I have chosen to utilise in this thesis.

3.2 Theoretical framework

In view of the centrality of the strategic use of language and discourse to policy, and the regulatory activity of the GMC (section 2.5), it is necessary to employ a theoretical and analytical framework focused on the use of discourse in policy, and on the discursive practices and processes involved in policy making. This discursive turn further facilitates my search for a deeper understanding of how power is generated, how power relations are expressed and the implications of these power relations (Woodside-Jiron, 2011) in UK medical education policy. In fact, the notion of discourse underpins the theory and thus forms the backbone of this thesis. Taking a hermeneutic approach to policy, and focussing on policy texts and other policy-relevant documents, I am not interested in investigating the subjectivities of individuals but rather aim at elaborating the social practices, social structures, power relations and meaning-making activities as these are expressed through the medium of discourse in medical education policy (Fairclough, 2003; Bacchi, 2000; Foucault, 1999, 1991b). This thesis is therefore theoretically grounded in discourse theory, Foucauldian governmentality and social constructionist theory.

3.2.1 Discourse theory

Discourse is widely represented as being about language, text, speech or statements and the communication of meaning. This is the basis upon which discourse studies often place a focus on lexical and grammatical structures using such approaches as Systematic Functional Linguistics (Halliday, 2009). But

discourse is not merely concerned with the communication of information from one to another, nor is it an inert linguistic mechanism that simply circumscribes what is possible to say, know or do. It is also a collection of temporally-defined practices aimed at the creation of meaning and the regulation of social conduct, which both creates, and is created by, the subjects of whom it speaks (MacLure, 2003; Cameron et al., 1999; Hajer, 1993; Foucault, 1991b; Ball, 1990). Importantly, it is a medium by which the bonds that hold society together are formed, and one by which the social role of individuals, groups and other social entities are defined and delimited (Ball, 1988), as well as a repository of social knowledge and memory, and a form of social practice (Weiss & Wodak, 2008; Mills, 2004; Parker, 1990).

That is not to say however that there is any semblance of consensus in the literature on what constitutes discourse, and there are almost as many definitions as there are publications. Parker, however, suggested that a utilitarian definition of discourse is that it is "a system of statements which constructs an object" (1990, p. 191) . In this definition he does away with the subject, and thus dehumanises the creation or generation of the statements he refers to while focussing attention on the object – that which the discourse constructs – and effectively segregates the notion of discourse from the social arena. However, discourse is not independent of the one communicating, or for that matter the recipient of the communication, but is constituted and reconstituted by the speaker or author, and received and interpreted by the recipient. It is therefore inextricably linked to the speaker/author to the extent that meaning is ascribed to the words as a direct result of their own intentions. It is important to note however, that such meanings as are ascribed by the author or speaker do not have a fixed meaning, and are thus contestable. Regardless however, to consider discourse independently of human agency, as Parker (1990) does in his definition above, is to reduce the meaning of discourse to merely a function of the lexical ordering (Ball, 1988) .

Discourse is distributed within a multi-factorial hierarchy in which the kind of discourse is dependent on which parties are in dialogue, and in which the effect of a particular discourse is directly or indirectly related to its relationship to other existing discourses (Macdonell, 1986). The application of limitations to, and regulation or silencing of discourses causes their modification, evolution, reproduction, multiplication and sometimes cleavage into new discourses in order to fit in the constraints imposed by such censorship (Foucault, 1999). Indeed discourse remains unchanged for as long as it is socially acceptable,

beyond which point changes occur to the discourse in order to keep it in acceptable social standing (Bourdieu, 1999, p. 506). Discourse is therefore a system for meaning-making, for the transmission and reproduction of meaning, and a mechanism for the construction of alternative meanings. It is also clearly a mechanism that is manifested both in spoken and in written language.

However, I draw on Michel Foucault's foundation for the theoretical basis of my understanding of discourse. Foucault defined discourse in a variety of ways in his numerous works, however, I will draw on two of his more salient descriptions of the concept. On one hand, Foucault described discourse as being comprised of statements in three categories (Foucault, 1972, p. 80) namely a) all statements in general regardless of the meaning or the intended purpose; b) any discrete and identifiable group of statements, and; c) the rules, regulations and structures, written or unwritten, that lead to the production of statements. On the other hand he defined discourse as being an integral part of a wider concept of *discursive practices* (Bacchi & Bonham, 2014; Mills, 2004; Foucault, 1981; Foucault, 1972). In the Foucauldian view therefore, all utterances or practices of any kind which have meaning, which give rise to, or produce the conditions for the emergence of other utterances or practices qualify as discourse.

Further, there is a Foucault-inspired perspective, to which I also subscribe, with some reservation, that focuses on the socially constructive effects of discourse. Foucault saw the individual as being constructed and shaped by discourse: what the individual can say, when it can be said, and under what circumstances is determined and influenced on a social scale by discourse and power relations (Foucault, 1972). Viewing the individual from a realist-functionalist background, I do not see the individual him/herself as being *constructed* by discourse, but rather shaped, subjected and scaffolded by it. Even in the complete absence of language and its use, the individual continues to exist even though what form this existence takes is a matter for debate. As Foucault himself argues, discourses are classically distinguished by their effect on the social place, identities and functions of those governed by them (Foucault, 1991b, p. 58). He makes no mention here of the 'reality' of the individuals and groups so governed.

In the Foucauldian perspective, discourse is not just language-in-use but comprises the subjects, objects, operations, concepts and theoretical options brought into existence by use of language, as well as all the sociological, political, economic, cultural and other relations that define and situate it among other

discourses (Hodges, 2012; Foucault, 1991b; Ball, 1990). As Hyland (2013) argues, this social conception of discourse encompasses the "institutions, activities and values" recursively recreated by means of language and language-related activity. He further argues " the point here is that we do not only use discourse to express our attitudes, ideas and understandings, but that these are themselves shaped by discourse" (Hyland, 2013, p. 3).

While I see the merits of the Foucauldian perspective on the role of discourse in social relations, I would argue that holding unswervingly to this deterministic view, appears to do away completely with the concept of agency, and thus places the responsibility for an individual's actions on whoever, or whatever external entity propagates the dominant discourse in any particular context. While it may be true that discourse shapes society and scaffolds what can be said and done, it does not mean that it determines *all* the actions of individuals or groups.

In spite of these difficulties, it is this particular theoretical foundation in Michel Foucault's work, where discourse is a particular collection of social practices of which statements form one part, that informs my understanding of what it means to analyse discourse and locates my approach to this research. Further, while I use a Foucauldian theoretical foundation in this thesis, I find Foucault's own work quite circumlocutory and thus difficult to gain a purchase on. However, I have found the work of authors who use Foucault's foundation as a springboard, such as Bacchi and Bonham (2014) and Bacchi (2009, 2000), easier to comprehend. It is thus the discourse analytical work of these Foucauldian scholars that I apply to this research.

3.2.2 Governmentality

Discourse is also the predominant means by which power is exercised through policy because "power is invested in discourse, equally, discursive practices produce, maintain or play out power relations" (Ball, 1990, p. 17). The use of discourse in governing society is thus inextricably linked to the exercise of power in the establishment, maintenance and modification of desired social relationships (Lynch, 2011; Foucault, 1982), and is a political mechanism by which those governing seek to attain their particular purposes (Haworth, 2006; Mann, 1986).

Foucault used the term *governmentality* to describe the strategies that help to define and redefine the limits, and extend the reach of, the exercise of specific forms of power and control over society, and lead to the production of definable and desirable societal outcomes (Foucault, 1991a, p. 103). It describes the collective, taken-for-granted thought of how governing ought to happen and how it happens, or simply the "mentalities of government" (Dean, 1999, p. 16). It presupposes an understanding of government which is not about ruling inanimate objects or territories, but importantly about governing people, and their relationship to each other and to the inanimate objects and territories one means to govern (Foucault, 1991a).

The use of discourse in order to leverage dominant power relations is central to establishing governmentality, and extending rule over society (Dean, 2010). It is usually as policy that such governmentality is leveraged in establishing, maintaining and extending rule and governance over society, and in providing the means by which the wishes of 'socially legitimated authorities' are articulated and put into play over individuals and groups in society (Ball, 2015; Hyatt, 2013; Goodwin, 2011; Woodside-Jiron, 2011; Miller & Rose, 2008; Saarinen, 2008; Bacchi, 2000; Gale, 1999; Ball, 1993, 1990).

3.2.3 Social constructionism

Social constructionism refers to a collection of differing yet related post-structural approaches to knowledge, reality and truth. The main business of social constructionism is to somehow explain the nature of the mechanisms by which individuals are able to identify, interpret, designate, describe or otherwise explain the essence of their experience of the world around them. It begins by problematising phenomena and ways of understanding 'reality' that are otherwise taken for granted (Burr, 2003; Bury, 1986; Berger & Luckmann, 1966). It further approaches our ways of understanding as being underpinned by a specific culture and history. Social constructionism treats reality as a subjective construction of individual experiences, and considers all knowledge as being dependent on social processes – not discovered, but constructed and maintained by social action (Burr, 2003; Bury, 1986; Berger & Luckmann, 1966).

The social constructionist approaches while not identical, all recognise yet minimise the importance of the influence of the physical world around us on society and social processes – noting the inability of

the physical world to modify knowledge (Nicolson & McLaughlin, 1987). However, they are all subject to accusations of inherent relativism and irrationality (Bury, 1986) particularly from the fields of natural science and other forms of positivistic empirical inquiry based on the scientific method. In spite of this clear epistemological problem, social constructionism offers a different, socially cognisant perspective on the society and how its rule and governance are effected. Drawing on critical theory, it treats all social interactions as being shaped and driven by ideologies, and thus naturally amenable to problematisation and social explanation. Further, it facilitates the study of how social relationships and practices may be strategically leveraged in order to effect and apply rule over aspects of society. Finally, it also permits a focus on the relationship between the art of governing and the identification of "problems specific to the population" (Foucault, 1991a, p. 99).

While I struggle to affirm all the tenets of social constructionism, I recognise its utility in facilitating an understanding of problem construction in policy. It is this turn to problematisation and its analysis that is key to providing a supporting framework to this study. But rather than focusing on the structure of the problematisations themselves, I am aiming to uncover the "meanings which, deliberately or unknowingly" (Foucault, 1991b, p. 59) are introduced into the art of governing, and the problematisations by which we are governed. I am further interested in the place, distribution, effects and conditions of such problematisations in which they have emerged within policy in particular.

Having laid the foundation for this thesis in the literature and theory, I now seek to answer the following research question: ***What is the problem represented to be in UK medical education policy?*** In the next chapter, I lay out the methodology and procedures by which I sought to answer this research question.

4 Methodology and Procedures

In this chapter I will draw on, and be informed by, my review of the literature and theory in chapter 3, to (re)establish the questions guiding my research, and to clarify the means by which I seek to find answers to them.

4.1 Methodology and procedures

This thesis is a post-structural critical policy analysis of contemporary UK medical education policy utilising documentary data. It is thus a documentary research study which is theoretically grounded in the wider realm of critical policy sociology.

4.1.1 Research Questions

My interest in this thesis is on problematisation, and the representation of problems in UK medical education policy. By focusing my attention on the way problems are represented, I hope to elucidate how UK medical education policy can be understood, the meanings and implications of the proposals it contains, and thus consider how it might be received, challenged, or contributed to. Informed by the literature on problematisation and problem representation in policy analysis, and cognisant of the shortfalls in the medical education policy studies literature, I formulated the following research question:

What is the problem represented to be in UK medical education policy?

In order to answer this broad research question, I started by asking, and answering in an integrated fashion, the following specific sub-questions, developed on the basis of Bacchi (2009, p. 48):

1. What are the 'problems' represented to be in UK medical education policy?
2. What presuppositions or assumptions underlie these representations of the 'problems' ?
3. How have these representations of the 'problems' come about?
4. What is left unproblematic in these problem representations?
5. What effects are produced by these representations of the 'problems'?
6. How and/or where are these representations of the 'problems' produced, disseminated and defended?
    (a) How could these problem representations be questioned, disrupted and replaced?

4.1.2 Positionality

I am an active full-time medical educator, and have previously been a medical student, postgraduate junior doctor and a practising clinician in that order. I therefore approach this research from the perspective of a technical-empiricist medical educator. All my previous academic and intellectual work has come from the positivist-realist tradition typical of medicine and medical education, and my experience of interpretivist research has been gained from my time on the Sheffield EdD course. I realise that my approach to this interpretive research is therefore influenced by my background, values and interests. However, in the tradition of interpretivist research, I acknowledge these 'biases' and intend to be reflexive of their impact on my findings by discussing, wherever necessary, how my positionality, assumptions and values may have influenced aspects of my research. I begin in the next section by articulating how these personal peculiarities have influenced by methodological stance.

4.1.3 Methodological stance

My positionality, aims and purposes, and the questions I have chosen to research, have influenced my choice of methodology, and the selection of procedures that I have chosen to apply (Hartas, 2010; Cohen, Manion, & Morrison, 2007; Sikes, 2004; Wellington, 2000). In considering my methodological stance, I have taken four main issues into consideration as follows.

Firstly, I aimed to critically analyse UK medical education policy. In particular, I sought to shed light on how problems are articulated and represented in the policy, and thus clarify which (or whose) interests are foregrounded and/or suppressed in its expression, and highlight the privileging and marginalisation of individuals and groups as a consequence of these problem representations. In so doing, I further aimed to contribute to the bodies of knowledge on problematisation in policy as a mechanism of governance in the social science, policy studies, higher education fields in general, and the medical education field in particular.

Secondly, my commitment in this thesis was (and still is) to a socially-focussed critical policy analysis in order to clarify the problematisations, lines of argumentation, power interaction and interplay, social practices, social relationships and other processes of social interaction inherent in the body of policy for medical education (Bacchi, 2009; Kamler, Comber, & Cook, 1997).

Thirdly, I sought to empower the fraternity of medical educators in the UK, individuals like myself whose work is directly regulated, influenced and affected by medical education policy. I write here of empowerment, not in the sense of giving power to those who have none, but rather in the sense of facilitating the construction of knowledge that could be utilised to leverage both existing and new power relations (Foucault, 1997, p. 17) in ways that benefit the educators themselves and medical education in general. Cameron et al. describe this as "*research on, for and with*" (Cameron et al., 1999, emphasis mine).

Finally, in this thesis I have taken a critical historical view of UK medical education policy since 1992, an era which has seen significant policy output by the GMC; and during which it has proactively leveraged its legal mandate over the regulation of medical education and training.

In view of both these issues and the research questions I have articulated above, and conscious of my intention to critically analyse UK medical education policy, I chose to use an interpretive methodology in this thesis. An interpretive approach enables engagement with issues which traditional medical education research is designed to penetrate. For instance, it facilitates the search for understanding, enables a deeper comprehension of semiotic phenomena that are both contextual and contestable, and helps to provide a clarity of theoretical underpinnings of social events (Wellington, 2000); all features of the kind of study I have chosen to undertake.

Further, I chose to focus on contemporary and historical documents and texts as a primary data source. This research is therefore a documentary research study (Cohen et al., 2007; Wellington, 2000; Platt, 1981) which is theoretically grounded in the wider realm of critical policy sociology (Gale, 2001; Taylor et al., 1997).

Given all the above however, I have been unremittingly conscious of the limits imposed on my research by my underlying pragmatic aim to meet the academic requirements of my doctoral thesis and course of study.

4.1.4 Research context

I selected the UK as the site of this study, and undergraduate and postgraduate medical education as the focus of this research primarily because of my own personal and professional background. During the time that I have been working in UK medical education, and certainly from the 1990's, I have been a witness to the significant changes in its regulation, and the implementation and impact of GMC policies. The resulting changes in medical education have had an insidious yet direct effect on my own practice, and thus piqued my interest in understanding them and uncovering their underlying rationale. As I have discussed previously, these changes have meant that the majority of the medical education literature relating to policy, and written by fellow medical educators, has been focussed on the implications and effect of the implementation of these policies (Musick, 1998). Perhaps more crucially, it is still unclear as to how educators like myself can engage with, understand, and perhaps influence UK medical education policy.

4.1.5 Data

The primary data for this study consisted of the GMC seminal medical education policy, *Promoting Excellence*, (GMC, 2015c) and its predecessors *Tomorrow's Doctors* (GMC, 2009, 2003, 1993). An outline of these documents is provided in table 4.1.5. These primary data are public documents made available online via the GMC website, that will form the entry points or 'practical texts' for my analysis of UK medical education policy (Bacchi, 2009; McCulloch, 2004). I use the term 'documents' here to connote written texts where neither the method by which the texts are *written*, nor the medium in which the texts are *embodied*, is necessarily limited (Scott, 1990, pp. 12 - 13). The data thus intentionally includes all documents, whether hard-copy paper, handwritten, typed or typeset, or those in electronic form.

***Tomorrow's Doctors* 1993** (GMC, 1993)	***Tomorrow's Doctors* 2003** (GMC, 2003)
A 28-page document comprising three main sections and two annexes. The sections – "introduction", "the committee's recommendations" and "principal recommendations" – comprise a total of 82 enumerated paragraphs. The annexes comprise a list of "attributes of the independent practitioner" and a reproduction of "Section 5 of the Medical Act 1983".	A 40-page document consisting of 6 main sections, and concluding with a 1-page glossary and a 5-page index. The sections – "introduction", "the main recommendations", "curricular outcomes", "curricular content, structure and delivery", "assessing student performance and competence" and "putting the recommendations into practice" – comprise a total of 108 enumerated paragraphs and itemised lists.
***Tomorrow's Doctors* 2009** (GMC, 2009)	***Promoting Excellence***, (GMC, 2015c)
This 108-page document begins with a 4-page foreword by the Chair of the GMC, and concludes with four appendices including a list of 32 required practical procedures, an enumerated list of 7 requirements of UK and EU law that apply to the policy, a list of 60 related documents to which the policy refers, a glossary, end notes and a 4-page index. The rest of the document comprises an enumerated list of 174 requirements of undergraduate medical education spread across 9 domains, and outlining evidence required for each domain.	This 51-page document contains a total of 76 requirements relating to 10 standards that are grouped into 5 themes. Each theme consists of three sections, namely: purpose, responsibility and requirements. The policy references 9 other documents published by the GMC and the Academy of Medical Royal Colleges, and explicitly co-opts two other GMC publications: the 20-page *Outcomes for graduates (Tomorrow's doctors) 2015* (GMC, 2015a) – containing the "outcomes … published in Tomorrow's Doctors (2009)" (GMC, 2015a, p. 1), and the 10-page *Outcomes for provisionally registered doctors with a licence to practise (The Trainee Doctor) 2015* (GMC, 2015b) – containing the "outcomes … published in *The Trainee Doctor* (2011)" (GMC, 2015b, p. 1).

Table 4.1: An outline of the documents comprising the primary data analysed in this thesis

Secondary data

In addition to these primary data were secondary data comprising documents contemporary to the policy process such as legislated policy documents, standards, guidance, discussion and consultation documents, agendas, papers and minutes of GMC council and related board/governance meetings. These secondary data are also available freely online, primarily via the GMC website, but also in the UK Government Web Archive [1].

4.1.6 Procedures

4.1.6.1 Documentary studies of policy

Since policy is quite often published in documentary form i.e. texts or documents, I expected that any discursive strategies such as problematisations will be reified in the means by which proposals and solutions are articulated within the policy documents (Burnham et al., 2008; Ball, 1990). I further expected them to contain allusions to the assumptions, perceptions, meanings, and understandings prevailing at the time at which the documents were created, and to the values and intentions of the policy actors. This is not to assert that these allusions are in any way accurate, or truly representative of the values and intentions of the authors but rather to suggest that the discourses and discursive formations embodied in policy documents *may* in some way reflect the values, intentions and ideologies of the policy actors, may convey meanings and interpretations that are both intentional and unintentional, and may thus be useful in uncovering the thrust of the policy proposals (Burnham et al., 2008, p. 250).

Also intrinsic to the discourses and discursive formations within such documents may be references and allusions to the power relations being exercised by means of the policy. As Colwell (1997) argues, the exercise of power causes discursive events to be organised in particular patterns and series in such a fashion that conforms to the accepted norm, that which is determined by the power relation and thus generally taken for granted. Changing the power relationship therefore changes the series of events, and

[1] http://www.nationalarchives.gov.uk/webarchive/

thus alters the narrative. Therefore, in these policy documents, it is these changes in series, events or discontinuities in discourse that signal changes in power relations. It is thus useful in the analysis of policy to map out the occurrence of discourses, where and when they emerged, were modified, became dominant and /or regressed and make connections where possible between the various discourses in order to identify any discursive patterns that may be significant to the policy.

Documents are useful as data sources for policy studies because, once produced, they act as a historical record that provides a snapshot of discourse at a particular point in time, if it can be determined exactly when a particular document was produced. Burnham et al. (2008) argue that a clearly defined procedure for determining the accuracy of a document, that is, how precisely it represents the creative event, is crucial for determining whether or not it is relevant. They urge, however, that since the accuracy of any particular document is difficult to determine, it is imperative to study as wide a range of documents that are representative of the event as possible to reduce bias.

Secondly, the choice of what to include in a document implies that there is something to exclude, and thus the omissions and silences in documents are just as important as the inclusions (McCulloch, 2004; Fairclough, 1999). Analysis of the document therefore permits the elaboration of how language is selectively utilised by the document's author(s) to produce, transform, maintain and reproduce particular ideologies, power relations, social relationships, social identities and social structures; elaborating the "social and ideological work" (Fairclough, 1999, p. 204) that the particular use of language is aimed at achieving. Asking how problems are represented (research sub-question 1 above), and which issues are silenced or left unproblematic therefore (research sub-question 4 above), seeks to shed light on these inclusions and omissions.

Determining which documents are pertinent to a particular policy is thus a key step in policy analysis. Burnham et al. (2008) categorise documents generated in response to a specific event or occurrence into primary, secondary and tertiary sources of data on the basis of the audience they are aimed at, and the relationship between document generation and the event itself. In their view, primary documents are those that are created as part of, or during an event and aimed at internal consumption; secondary documents are created as a result of an event but targeted at public consumption; and tertiary

documents are created long after the event in question to reconstruct the event – also targeted at the public. McCulloch (2004) on the other hand considers documents as being in two categories: those produced with the involvement of the researcher and those created for purposes other than research or academic inquiry.

In contrast, several other authors consider all documents, however and whenever produced, as secondary data sources. These authors consider primary data as that which is directly derived from human sources (Cohen et al., 2007; Wellington, 2000; Platt, 1981). On the one hand Burnham et al. (2008) and McCulloch (2004) are considering documents in isolation from humans, while these other authors are considering documents and human sources together.

In this thesis I consider policy documents produced by the GMC for purposes other than my research[2], that have been primarily aimed at public consumption. Drawing on and adapting the document classification criteria of both McCulloch (2004) and Burnham et al. (2008), I classify these documents as primary and secondary data sources; where primary data are the main policy documents (defined as such by the GMC) and include consultation documents and meeting papers relating to the policy process, and secondary data include all other documents created to provide guidance, clarification and further information in addition to the these primary data.

4.1.6.2 Contextual analysis

Such documents as I describe above however, represent the outcome of struggles, negotiations and compromises in intended and received meaning. Further, as Burnham et al. argue, documents only " …acquire significant meaning when situated within a context set by vigorous analytical and methodological assumptions" (Burnham et al., 2008, p. 212). In fact the interpretation of policy documents is dependent on the context in which they are read (McCulloch, 2004; Codd, 1988).

Contextual analysis permits an examination of the chronological construction of policy, the influence of external discourse(s) on it, and elucidates how policy itself draws on and utilises discourse (Woodside-Jiron, 2011; Fairclough, 1999). As Woodside-Jiron asserts:

[2] a list of these documents is reproduced in the appendix (Appendix A)

> "Situating fine-grained discourse analysis in political and cultural context allows researchers to both explore cultural models and how they interact with moments of change, and to examine how educational processes and practices are constructed across time and how discourse processes and practices shape what counts as knowing, doing, and being within and across events" (2011, p. 158)

Therefore, in this thesis I explicitly recognise and take into account the historical, cultural and sociopolitical context of the development, publication and implementation of UK medical education policy in my analytical approach. The second and third of my research questions, namely 1. what presuppositions and assumptions underlie these representations of the 'problems', and 2. how have these representations of the 'problems' come about? provide the intellectual leeway to interrogate the context of policy. I specifically draw on historical and contemporary data from significant political events such as changes in the UK government, or in higher education policy and oversight that were contemporary to the policy process, as well as news articles and other contemporary texts to form a contextual backdrop to the data above. This contextual data is essential to a rigorous policy analysis as it helps define and delineate the wider context in which the policy exists and can thus be understood. (Taylor et al., 1997; Codd, 1988).

4.1.6.3 Authors' intentions

Burnham et al. (2008) argue that it is not possible to make sense of an author's intentions by merely studying a document unless the context in which it was produced is clarified. They thus imply that if the context of a document is known then one can begin to fathom the author's intentions. However, the assumption that policy documents contain within them the intentions of the authors rendered as text exposes one to "intentional fallacy" (1988, p. 236). Such an assumption presupposes that the meaning implied by a mere reading of the text corresponds to the author's intentions, and that the text can thus be taken as evidence of these intentions.

As alluded to earlier, coming from the "technical-empiricist" (Codd, 1988, p. 237) mindset, it is my view that policy documents do indeed contain the textual expression of the author's intentions and meanings – whether or not these are accurately representative of the author's real intentions is impossible to determine particularly in view of the tendency of authors to portray themselves or their role favourably

(McCulloch, 2004, p. 33). How those intentions and meanings presented in textual form are received and interpreted may not therefore accurately represent either the author's original intentions or the written statements of intention.

Codd does point out however, that there is a distinction between what is intended on the one hand and statements of intention on the other. He further asserts that what is intended may not necessarily be expressed correctly since "people may be mistaken about their own intentions" (1988, p. 239). His argument, however, that the only purpose of the study and deconstruction of policy documents should be to elaborate what the multiplicity of effects of a policy would be upon its recipients, and *not* to uncover the author's intended meaning, is in my view myopic at best. I would argue that such deconstruction as he describes, serves the more pertinent purpose of elucidating the *implied meaning*, *assumptions*, *perceptions*, and *understandings* of the discourses codified in the text and, as such, uncovers the expressions of the exercise of social and political power through the medium of discourse.

Documents therefore lend themselves quite naturally to the study of discourse. The conceptual links between discourse on the one hand, and social structure, relationships and processes on the other, is important for the exploration of policy documents, and justifies drawing on discourse theories and methods in their analysis. It is in this light therefore that I intend to apply the tools of critical policy sociology (Gale, 2001) to the deconstruction, characterisation and analysis of medical education policy; de-constructing the ideological substructures upon which the policy has been constructed, and disinterring how these have been privileged, foregrounded and in some cases attained the status of taken-for-granted 'truths'..

There are a myriad ways by which discursive policy deconstruction and characterisation may be carried out, however, a reliance on Foucault's approach provides a conceptual toolbox containing useful lenses by which semiotic choices and relations in policy may be identified and studied; tools which permit the careful critical consideration of whose interests are served by such choices. These lenses, *archaeology*, *genealogy* and *historiography* (Gale, 2001) are by no means mutually exclusive and may, from certain perspectives, appear to be a mere retelling of the same story. In fact, all three lenses are historiographic in the sense that they entail a "study of the history of historical writing" (Cheng, 2012, p. 1). Usefully however, they form a theoretical and conceptual toolbox to facilitate the analysis of policy in particular ways. I will briefly discuss these lenses below.

4.1.7 Methodological lenses

4.1.7.1 Policy Historiography

Policy historiography is a historical analysis of policy in an attempt to trace the appearance, modification and evolution of policy changes, and to elucidate the relationships between such changes and events in the past and the present. Starting with events in the past, this approach is used to explain and trace the development and evolution of policy discourses and discursive shifts. A critical historiographic approach to policy further seeks to inquire about any complexities between coherent accounts of policy and how these advantage or disadvantage policy actors.

4.1.7.2 Policy Archaeology

Policy archaeology is itself a historiographic [2] technique that seeks to characterise the emergence of particular agendas by making the following policy spheres the object of critical analysis: a) the social and discursive circumstances that made the emergence of specific policy problems possible, b) the frameworks within which problems, 'real' or 'constructed', are either assigned the status of policy problems or not, and c) how these aforementioned frameworks help to form the regulatory and discursive boundaries within which policy choices are shaped, and under which policy analysis may be undertaken (Gale, 2001; Scheurich, 1994). This approach therefore sits in the middle of the methodological continuum where it covers similar ground to that of policy historiography and genealogy (Gale, 2001, p. 387).

4.1.7.3 Policy Genealogy

In contrast, policy genealogy – yet another historiographic[2] technique – focuses on chronological changes or discontinuities in policy. It problematises taken-for-granted rationality and consensus, and is interested in the formation, dissolution and reformation of strategic alliances as a result of changing

[2]The term 'historiographic' is used here in its generic sense to denote the "study of the writing of history and of written histories" (Historiography, 2017)

interests in the policy process (Gale, 2001). It is this latter interest in strategic alliances between policy stakeholders that Butler focuses on in her description of the use of policy genealogy as a means of evaluating "the political stakes in designating as an origin and cause those identity categories that are in fact the effects of institutions, practices, discourses with multiple and diffuse points of origin." (Butler, 1990, pp. viii-ix).

Using the genealogical approach permits the deconstruction of the series of discourses, events, isolated instants or singularities inherent in the policy process, even though these may be unrelated to time or to each other, except in those ways that the particular policy process dictates (Colwell, 1997). The events at stake here may remain invisible but produce the visible structures of experience.

As Foucault himself described this lens "I set out from a problem expressed in the terms current today and I try to work out its genealogy. Genealogy means that I begin my analysis from a question posed in the present" (Foucault & Eward, 1988, p. 262). In like manner, in this thesis I have identified key problematisations in contemporary UK medical education policy and used the geneaologic lens to help chart their emergence, rise to prominence, persistence and/or dissipation.

Using the genealogical approach thus further permits the reconstruction of the events in order to challenge the taken-for-granted meaning and interpretation of events, discourses and concepts, and thus facilitates the retelling and "making strange" (Kuper, Whitehead, & Hodges, 2013, e849) of the relationship between events, their accepted meaning, and their interpretation. This in effect facilitates the retelling of the story, or process from multiple perspectives, changing the way events are serialised, related and linked in order to determine the significance and meaning of individual events and elucidate any power/knowledge relationships.

I utilised a combination of these lenses to identify, elucidate and describe how problems are represented; identifying, describing and estranging those representations and related discourses viewed as self-evident, normal or taken-for-granted (Scheurich, 1994). These methodological lenses provided a theoretical basis for the analysis of policy, but perhaps because of their overlapping nature, or because of my positivistic leanings, and for want of a reproducible framework with which to use them, I found that the lenses themselves did not discretely define procedures and processes by which policy

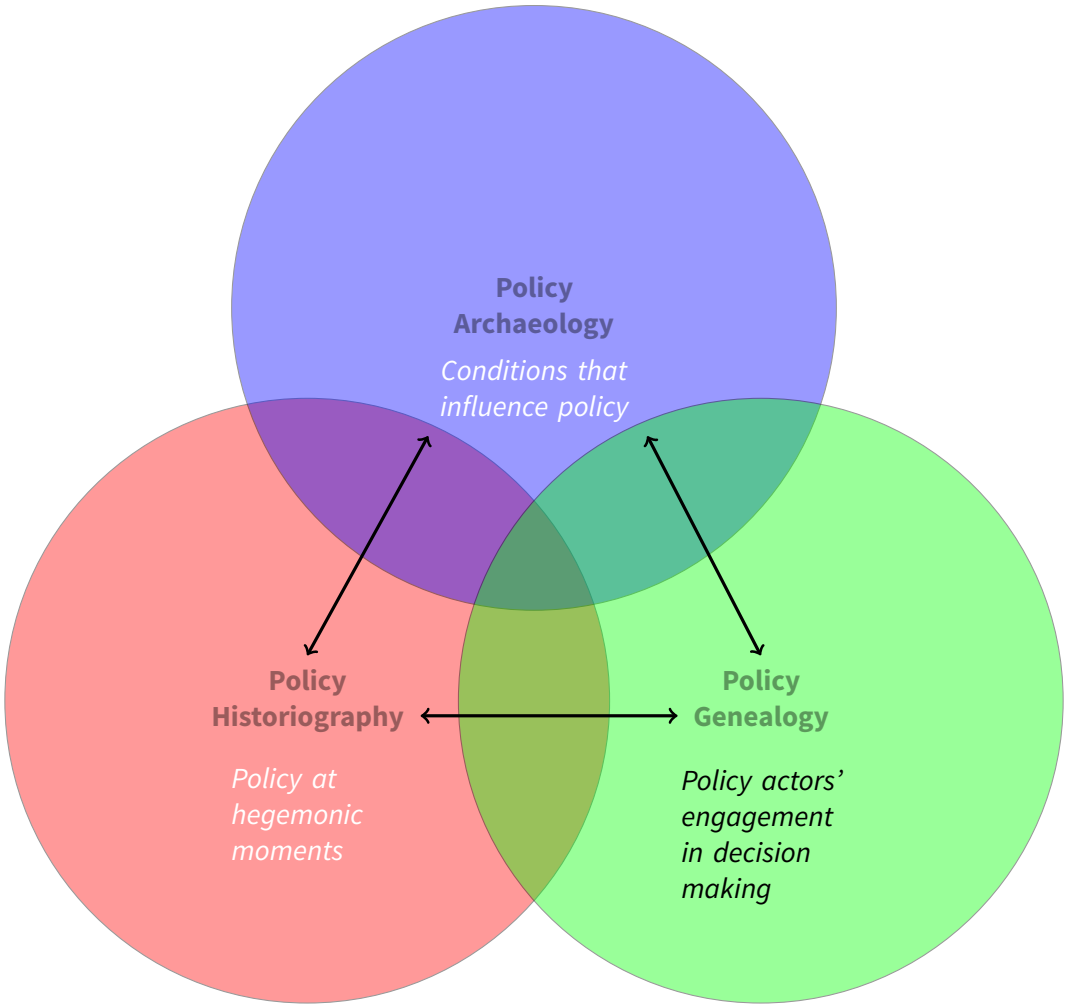


Figure 4.1: An illustration of the overlapping and symbiotic relationship between the methodological lenses (adapted from Abedin, 2013)

analysis could have been carried out. I therefore chose to utilise the WPR framework (Bacchi, 2009), an approach which applies these Foucauldian methodological lenses in a more 'positivist-friendly' fashion. As Goodwin asserted, the WPR framework provides "a *systematic* way of exploring the discursive aspects of policy, including how problems are represented in policy and how policy subjects are constituted through problem representations" (Goodwin, 2011, p. 167, emphasis mine). As I have already discussed previously, Bacchi (2009) draws on Michel Foucault's own work and on the intellectual traditions of social construction and feminist body theories, post-structuralism and governmentality studies, and provides a comprehensive check-list to guide the analysis of policy.

In table 4.2 below, I illustrate how my research questions (derived and modified from Bacchi, 2009) map onto the three methodological lenses.

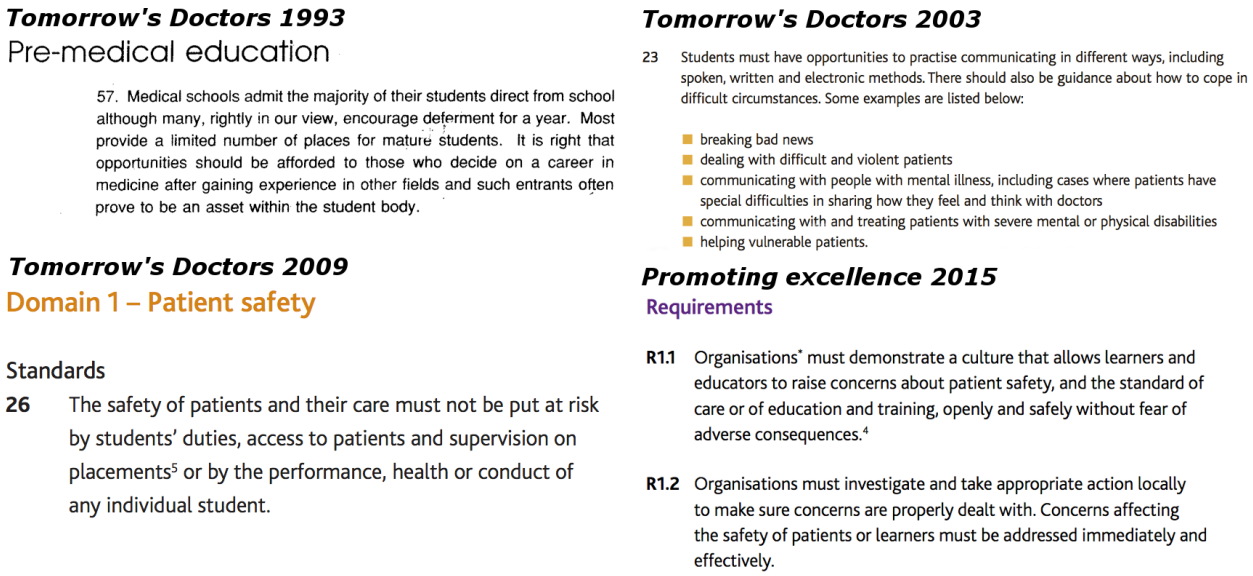
Research question	Historiography	Archaeology	Genealogy
1. What are the 'problems' represented to be in UK medical education policy?	✔	✔	✔
2. What presuppositions or assumptions underlie these representations of the 'problems' ?	✔	✔	✔
3. How have these representations of the 'problems' come about?	✔	✔	✔
4. What is left unproblematic in these problem representations?		✔	✔
5. What effects are produced by these representations of the 'problems'?	✔	✔	✔
6. How and/or where are these representations of the 'problems' produced, disseminated and defended?	✔	✔	✔
6a. How could these problem representations be questioned, disrupted and replaced?		✔	✔

Table 4.2: Mapping the research questions to the methodological lenses.

4.1.8 Data Analysis

In keeping with the basic tenets of a WPR approach, I tackled the analysis of UK medical education policy by the recursive and reflexive application of a check-list of the six research questions that were derived from Bacchi (2009) and listed in section 4.1.1 above as follows. The *Promoting Excellence* (GMC, 2015c) policy formed the starting point for analysis, with the preceding *Tomorrow's Doctors* (GMC, 2009, 2003, 1993) policies providing the historical data and underpinnings for analysis. I focused primarily on the 'proposals for change' articulated in the policy as I analysed how 'problems' were conceived, presented and represented (as inevitable or natural 'truths'). The data was contextually and sequentially analysed for statements alluding to problems targeted or solutions posited, and functional or coercive methods by which policy implementation would be regulated and regularised, and where such statements or expressions were either absent, hidden, or in any way less than overt, implicit statements or expressions of the same were sought. I quickly found that significant steps had been taken to sanitise the documents of any clear proposals articulating problems and solutions, perhaps for the fear of appearing biased.

Indeed, the vast majority of the policy documents was articulated in the form of curricular requirements (Figure 4.2). I was however, able to decipher the 'problem' representations in these documents by focusing on the multiplicity of statements articulating the obligations of various actors – often using the modal 'must'.



Tomorrow's Doctors 1993

Pre-medical education

57. Medical schools admit the majority of their students direct from school although many, rightly in our view, encourage deferment for a year. Most provide a limited number of places for mature students. It is right that opportunities should be afforded to those who decide on a career in medicine after gaining experience in other fields and such entrants often prove to be an asset within the student body.

Tomorrow's Doctors 2009

Domain 1 – Patient safety

Standards

26 The safety of patients and their care must not be put at risk by students' duties, access to patients and supervision on placements[5] or by the performance, health or conduct of any individual student.

Tomorrow's Doctors 2003

23 Students must have opportunities to practise communicating in different ways, including spoken, written and electronic methods. There should also be guidance about how to cope in difficult circumstances. Some examples are listed below:

- breaking bad news
- dealing with difficult and violent patients
- communicating with people with mental illness, including cases where patients have special difficulties in sharing how they feel and think with doctors
- communicating with and treating patients with severe mental or physical disabilities
- helping vulnerable patients.

Promoting excellence 2015

Requirements

R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.[4]

R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.

Figure 4.2: Snapshots of the policy documents (GMC, 2015c, 2009, 2003, 1993) illustrating the curricular nature of their textual content

Central to the policy analysis was the use of a bespoke data extraction spreadsheet developed in Microsoft Excel®. A separate table, as illustrated in Table 4.3, was created for each policy, with a) 6 columns, each one relating to a single research question (section 4.1.1 above), and b) 6 rows comprising the theme of 'patient safety', as well as the five themes into which the standards and requirements of *Promoting Excellence* 2015 were categorised, namely: 'learning environment and culture', 'educational governance and leadership', 'supporting learners', 'supporting educators' and 'developing and implementing curricula and assessments'[3].

In tandem with the identification of problem representations, each policy was de-constructed in order to identify, critically analyse and discuss its discursive features, and examine how these were being utilised in the legitimation of the policy, the construction and maintenance of preferred power relations, and the

[3] An extract of *Promoting Excellence* (GMC, 2015c) illustrating the relationship between these themes is contained in appendix D

	Research Questions					
Theme	Q1	Q2	Q3	Q4	Q5	Q6
Patient Safety						
Learning environment and culture						
Educational governance and leadership						
Supporting learners						
Supporting educators						
Developing and implementing curricula and assessments						

Table 4.3: Basic structure of the data extraction table utilised in the analysis of the policies

expression of the interests and values of the various stakeholders in the policy. This process facilitated deeper exploration of the foundation, presumptive basis, historiographic characteristics and effects of the 'problems', and the consideration of alternative ways in which the 'problems' could be conceived and represented. Each of these problematisations and problem representations were then entered into the assigned table[4]. This was done to facilitate mapping the relationship between the problematisations and the recursive application of the research questions, and a comparison between the policies.

Additional related texts[5] were further selected and added to the data on the basis of their relevance to the problem representations thus uncovered, or on their relevance to the sociopolitical context of the policy. The policy was thus subjected to an integrated, recursive and reflexive critical analysis utilising the six research questions of the WPR framework.

4.1.9 Ethics

In order to ensure that this research was achievable within the constraints of the doctoral study, and to ensure methodological rigour within these constraints, I determined to limit my data as described earlier, to written, paper or electronic documents and texts. Further, because the GMC is a public body, a significantly large proportion of the documents and texts I require for the study are publicly available and published on the GMC website. A few documents are archived by the GMC as paper copies but nonetheless publicly available.

[4] A snippet of one of these tables as used is included in Appendix C
[5] A list of these documents is reproduced in the appendix A

In view of the public accessibility and availability of the data required for my study, formal research ethics approval was not required. Nonetheless, throughout the research and development of this thesis, I remained cognisant of the fact that some of this data may allude to identifiable individuals. However, since the thrust of my study was on language, practices and power rather than the activities of specific individuals, such identifying and identifiable data which may have emerged during the course of my study was deemed irrelevant, and was thus excluded.

5 | Analysing UK Medical Education Policy

In this chapter I have critically analysed *Promoting Excellence* (GMC, 2015c), uncovering what the problem(s) is/are represented to be, and considered the implications that such problem representations bear. I have also draw on the predecessors of this recent policy, *Tomorrow's Doctors* (GMC, 2009, 2003, 1993), considering what the problems are represented to be in these versions of the policy, and critically analysing how they relate to each other and to *Promoting Excellence* (GMC, 2015c) in the diachronic sense, and to the socio-political context in which each of them were formulated and published.

In its most recent medical education policy, *Promoting Excellence* (GMC, 2015c), the GMC articulates five themes that represent the broad areas over which they wish to establish control, and thus articulate the problems and propose solutions, namely: "a) learning environment and culture; b) educational governance and leadership; c) supporting learners; d) supporting educators, and; e) developing and implementing curricula and assessments" (GMC, 2015c, pp. 6-7). In addition, drawing on the assertions of the GMC in which it describes itself as an "independent organisation that helps *to protect patients*" (GMC, 2016b, emphasis mine), both this recent policy and its predecessors make a major claim to having been formulated for the express purpose of ensuring the safety of patients. Nevertheless, *Promoting Excellence* (GMC, 2015c) and its predecessors are not singular proposals relating exclusively to patient safety, but rather a compilation of proposals that represent the problem differentially, and under-gird the declared themes of interest to the policy maker. This most recent GMC policy is multifaceted and makes multiple specific proposals covering the breadth of UK medical education. In her report to the 2nd June 2015 Council meeting, the then GMC Director of Education and Standards described the multiplicity of proposals in this policy and its predecessors as follows:

> "The new standards replace parts of Tomorrow's Doctors and The Trainee Doctor that cover managing and delivering medical education and training. Those two documents were set out under *nine domains* with a total of *24 standards* and *259 requirements*. The documents set out processes describing how the standards were to be met, and evidence to be provided.We have reduced this to *ten high level standards*, structured around *five themes*, applying to both undergraduate and postgraduate education and training. We have *76 requirements* setting out what an organisation must do to show us they are meeting the standards" (Osgood, 2015, p. 2, emphasis mine)

Rather than restrict my discussion to the aforementioned themes articulated within *Promoting Excellence* (GMC, 2015c) however, I have structured my analysis and discussion along the lines of the predominant representations of the problems in two major sections. In the first section, I deal with the two predominant representations of the problem: *patient endangerment* and *individual responsibility*. These two representations are predominant not because they form the major part of the explicit proposals contained within the policy, but because they not only stand alone as distinct problem representations, but also form discursive threads that run through and link to the other representations of the problem(s). The second section covers other singular representations of the problem, as well as a short synopsis of those representations that emerged in previous policies but have been silently discontinued or replaced.

5.1 Patient endangerment and individual responsibility

5.1.1 Patient endangerment

In *Promoting Excellence* (GMC, 2015c), the GMC represents the core problem, and one to which most of its further representations are linked, as one of 'patient endangerment' *by* learners and doctors, and *in* particular learning environments and learning cultures. It asserts for instance that "patient safety is at the core of these standards" and "patient safety runs through our standards and requirements" (GMC, 2015c, p. 5). This representation of the problem is implicitly constructed by the promotion and privileging of the discourses of *risk* and *patient safety* throughout the policy. As discussed in the introduction to this chapter, the GMC argues that *patient safety* is essential to all the proposals it subsequently makes in the policy. The GMC is further explicit in its requirement that doctors, medical students, and organisations

take active steps to ensure and maintain patient safety, and to respond to any concerns raised in this regard. That patients should be safe however, is a presumption that is taken for granted, even though the term 'patient safety' is itself an oxymoron; identifying an individual as a patient immediately implies that they have a condition that represents a current insecurity of their well-being. In addition, ascribing to an individual the status of 'patient' bears the implication that the individual is receiving health care and is thus either already safe or is being made safe(r).

Patient safety is a dominant discourse that has gained traction globally in the fields of healthcare and medical education. As such, the discourse is not new to UK medical education policy, but first emerging with tentative steps in the first version of *Tomorrow's Doctors* (GMC, 1993), it has increasingly gained prominence with each iteration of the GMC medical education policy. In fact, the term "patient safety" does not appear anywhere in the text of *Tomorrow's Doctors* (GMC, 1993). Instead there is a single, extremely tenuous reference to the safety of patients, where it referred to the requirement for medical students to have acquired the disposition to take some responsibility for ensuring "individual patient welfare" (GMC, 1993, p. 14). As seen here, the problem was represented as one of *welfare*, that is patients' happiness, health and good fortune, and not on the prevention of harm as a result of healthcare related activities as it is later represented. Representing the problem as one of 'welfare' had the perhaps unforeseen effect of enlarging the remit of possible solutions to this policy problem, beyond the confines of healthcare facilities and into the wider society, and thus making the overall responsibility for provision of such welfare an issue for the state.

In *Tomorrow's Doctors* (GMC, 2003) however, the GMC had a single direct reference to patient safety – asserting that "if students have concerns about patient safety, they must report these to their medical school" (GMC, 2003, p. 32). This reference was sequestered among several other references to the prevention of harm in general such as "health and safety of the public" (GMC, 2003, p. 5), as well as allusions to the wellbeing of medical students themselves, such as the need for them to be provided with "appropriate support for their academic and general welfare needs", and to be cognisant of the "importance of looking after their own health" (GMC, 2003, p. 21).

By the selective truncation of the notion of 'patient welfare' in this newer policy, and the introduction of the mutually exclusive discourses of 'patient safety' on one hand, and 'student health and welfare'

on the other, *Tomorrow's Doctors* (GMC, 2003) thus introduced the notions of patient endangerment and individual responsibility into its representation of the problems. It also effectively transformed the construction of the issue of safety in the healthcare setting, from an emphasis on *welfare* to one on the *prevention of harm* to patients whilst they were receiving healthcare. The truncation of 'patient welfare' is consistent with an ideological move away from the perspective of health as an indispensable human right, which has significant social implications and whose provision is the indisputable responsibility of the state, to the neo-liberal view of health as an individual issue that is determined by factors such as the individual's choice of habits and behaviours (Wiest, Andrews, & Giardina, 2015). Also inherent in the entrance of the discourse of *patient safety* into *Tomorrow's Doctors* (GMC, 2003) is the construction of the notion of patient safety as an issue of risk. The implication made in this re-construction of safety is that there are risks associated with being in healthcare. In the policy however, these risks are constructed as resulting from the malevolence of individuals (Heyman, 2010, p. 52) and groups involved in the delivery of the health care. In fact, *Tomorrow's Doctors* (GMC, 2003) further stressed the need for medical students to have an awareness of the "importance of protecting patients" (GMC, 2003, p. 32), discursively constructing the presumption of the existence of a risk from which patients would need to be protected.

By the time of the publication of the 2009 version of *Tomorrow's Doctors* (GMC, 2009), *patient safety* had gained such prominence and privilege as a discourse that it was afforded a special place as the foremost of nine discrete "domains" (GMC, 2009, pp. 31–35) into which the GMC's standards were divided. In fact, direct and explicit reference was made to the risks posed to patients, by medical students, in pronouncements such as "the safety of patients and their care must not be put at risk by students' duties, access to patients and supervision on placements or by the performance, health or conduct of any individual student" (GMC, 2009, p. 31). Emerging prominently in this policy therefore, was the notion of individual responsibility, that is, the responsibilities of students, among other references to the notion. The GMC further emphasised the need for medical schools to identify such problematic students, and prevent them from graduating and thus receiving the right to a medical license. It asserted " medical schools have a responsibility … to ensure that only those students who are fit to practise as doctors are allowed to complete the curriculum and gain provisional registration with a licence to practise" (GMC, 2009, p. 35).

Even though it took a while for it to gain traction in UK medical education policy, patient safety had long been an issue of significant academic and public debate (BBC, 2001b; BBC, 2000; National Academy of Sciences [NAS], 2000; Airey & Erens, 1999). Contributing to the public debate however, the news media coverage had, and has been, quite one-sided with far more air time given to stories reflecting the failures of individuals and organisations, and almost none set aside for narratives describing successes in respect to patient safety. As Palmer and Murcott (2011) argue, it is this distorted picture of patient safety that drove the establishment of the National Patient Safety Agency (NPSA) in 2002, and the rise to prominence of the patient safety as a policy problem. In fact, it was a whole seventeen years after the publication of *Tomorrow's Doctors* (GMC, 1993), and in response to a report by the NPSA, that the first parliamentary debate on patient safety was held at Westminster (Russell, 2010). It is key to note that the notion was rising in relative importance in the literature, in practice and in policy, significantly in advance of its identification as an issue significant enough to warrant a parliamentary debate. This discordance reflects the dissonance between the development of an issue as a *policy problem* and its perception as a *social problem*, and re-emphasises the importance of the study of problematisation in policy analysis.

Nevertheless, patient safety is a notion that means different things to different people. For instance, writing from a North American point of view, Ziv, Small, and Wolpe make the argument that patient safety refers to "freedom from *accidental* injury" (Ziv et al., 2000, p. 489, emphasis mine). They emphasise the point, in this definition, that patient safety relates to issues of coincidental and unintentional harm. They then further argue for the "institutionalization of simulation as a part of medical education and performance assessment" (Ziv et al., 2000, p. 494, emphasis mine) and thus represent the problem of patient endangerment both as an issue of risk, and as an issue of (lack of) investment and finances. Of the various other conceptions of the notion of patient safety, the World Health Organisation defines it in terms of the minimisation or elimination of "incidents which occur during health-care delivery and cause unintentional and preventable harm to patients …" (WHO, 2011b, p. 3); Peter Davis argues that it is both a "public health issue" and a "matter of human rights" (Davis, 2004, p. 1689); Clinton and Obama (2006) argue it is an issue of medicolegal liability, and; Emanuel et al. (2008) define it as both an academic/professional discipline and as a feature of healthcare provision as follows:

"Patient safety is a discipline in the health care sector that applies safety science methods

> toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events" (Emanuel et al., 2008).

On the other hand, Wilson et al. (2012), writing from the point of view of the 'developing world', described patient safety as the prevention of 'adverse events' which they defined as "*unintended* injury that resulted in temporary or permanent disability or death (including increased length of stay or readmission) and that was associated with healthcare management rather than the underlying disease process." (Wilson et al., 2012, p. 2, emphasis mine). Like Ziv et al. (2000), they emphasise the coincidental and unintentional nature of events leading to patient harm. However, they represent the problem as one of "healthcare management", highlighting the fact that it could be both an individual and an organisational issue. In contrast, and from a UK perspective, the GMC represents patient safety as issue of the actions of individuals or the "systems, policies and procedures in the organisations where they work" (GMC, 2012, p. 7), while to the Royal College of General Practitioners it is the "prevention of errors and adverse effects for patients associated with health care" (Royal College of General Practitioners [RCGP], 2016).

However disparate these descriptions of patient safety are, they are linked by the privileging of the discourse of *risk*. While in common use the term 'risk' connotes the presence of a likelihood of danger by virtue of a property integral to an object or activity, here it takes on the nature of a social construction; a characteristic which greatly facilitates the discursive construction in policy of propositions aimed at alleviating the now underscored risk (Bradbury, 1989). The privileging of the discourse of *risk* also foregrounds the likelihood of adverse events which *per se* are otherwise sporadic and infrequent. In essence, this demonstrates how the discourse of *patient safety* is privileged, supported and under-girded by a concurrent discursive reliance on the measurement and management of risk with a view to implementing control over health care activities in which patients are involved? As Waring (2009) argues, *patient safety* in practice is a discourse that is both produced and privileged by "social interaction, collective sense-making and through engaging in the technological processes associated with risk management" (Waring, 2009, p. 1730). Ultimately, the construction of patient safety as an issue of risk simplifies, categorises and frames it as a measurable and quantifiable phenomenon that lends itself to managerialism, but at the same time obfuscates any dissimilarities within, and any similarities between,

categories of similar phenomena (Heyman, 2010, p. 38). Notably however, while risk is at the heart of the patient safety emphasis of *Promoting Excellence* (GMC, 2015c), the policy is silent in regard to the issue of intention insofar as patient endangerment is concerned. By keeping silent on intention, the policy implicitly privileges the coincident representation of the problem as one of individual responsibility (section 5.1.2), but at the same time leaves the matters of jurisprudence in regard to the welfare of patients receiving healthcare unarticulated.

On one hand, there is an assumption that ensuring patient safety is synonymous with treating a patient's medical condition and making a return to full health a certainty. On the other hand however, one may also assume, as the GMC does, that patient safety relates to the prevention of unwarranted harm, and not necessarily to any other activities or outcomes related to the provision of healthcare itself. In this sense therefore, whereas treatment may itself cause harm as a mechanism of its side effects, this is an expected or 'warranted' part of healthcare and is therefore not considered an affront to patient safety. The 'unwarranted' harm referred to here relates to that arising from the decisions, actions or conduct of individuals. Perhaps as a direct result of these discordant perspectives on what constitutes patient safety, and the assertion that learners and doctors trained in countries other than the UK may have a different comprehension of what it entails than those trained here, there are significantly more disciplinary procedures instigated by the GMC against foreign-trained doctors than those trained in the UK (GMC, 2015d, p. 24). The GMC does not explicitly address this assertion in their policy documents, however, other related publications, consultations and reports address it more distinctly. For instance, in their report following an investigation commissioned by the GMC into allegations of racism and discrimination against foreign-trained doctors in a postgraduate specialist examination, Esmail and Roberts (2013) implicitly asserted the view that patient safety is perceived differently in the UK than in other countries, stating the following:

> "The CSA is not a culturally neutral examination and nor is it intended to be. It is not and nor should it be just a clinical exam testing clinical knowledge in a very narrow sense. It is designed to ensure that doctors are *safe to practise in UK general practice*. *The cultural norms of what is expected in a consultation will vary from country to country*. So for example, a British graduate will have difficulty in practising in a general practice setting in France or in India until they become acculturated to that system of care" (Esmail & Roberts, 2013, p. 15, emphasis mine).

As a result of this perspective, as Leach and Donnelly (2012) reported, three out of four of those learners and doctors struck off the medical register are foreign-trained. Representing the problem as one of patient endangerment therefore, implicitly constructs non-UK medical education as inherently unsafe. The result is the construction of foreign-trained doctors as 'bad' and their UK-trained colleagues 'good' – until proven otherwise. Foreign-trained medical students and doctors are thus less likely than their UK-trained peers to secure certain appointments or to progress up the ranks of the profession (Kyriakides & Virdee, 2003). With the majority of foreign-trained students and doctors in the UK being non-caucasian, I would contend that this may indeed be a thinly veiled expression of institutional racism (Cooke, Halford, & Leonard, 2003).

Equally important to note here, is the fact that there are a couple of key assumptions that the representation of the problem as one of patient endangerment in *Promoting Excellence* (GMC, 2015c) makes. By asserting that "good medical students and doctors make the care of their patients their first concern" (GMC, 2015c, p. 5), the assumption is made that such a focus is always going to be beneficial to patients, which may not necessarily be the case. For instance, and without professing any knowledge of his true motivations, it could be argued indeed that Harold Shipman, the now vilified rogue doctor, had the care of his patients as his first concern. As Soothill and Wilson report, before gaining public notoriety he was widely regarded by his patients as a "particularly good, 'old- fashioned' doctor – especially with elderly people, whom he was prepared to visit in their own homes" (Soothill & Wilson, 2005, p. 688). In making this assertion at the outset however, and emphasising the primacy of the care of patients to individual medical students ('learners' hereafter – a concept introduced in *Promoting Excellence* (GMC, 2015c) that encompasses both medical students and junior doctors still in training) and doctors, the GMC draws on the discourse of *individual responsibility*. It constructs concern for patients as the exclusive responsibility of individual learners and doctors. By making this a question of individual responsibility, the policy further constructs a discursive dichotomy of 'good' and 'bad' learners or doctors; the 'good' representing those that are able to demonstrate this concern, and the 'bad' as those that are not able to. However, it is noteworthy that there is no attempt by the policy to articulate exactly how this concern may be demonstrated. In fact, there is no insinuation that an individual would have any need to actively demonstrate the possession of such concern, but rather, there is an implication that any lapse in patient

safety would provide the regulator with the grounds to retrospectively challenge an individual's actions as showing lack of such concern.

The second assumption that this representation makes is that the construct of a *good doctor* is one that is universally understood and presents no intellectual or semantic controversy. In fact, the *good doctor* is a construct that has undergone significant change over at least the last century (Whitehead, 2011), and still remains without general consensus. On one hand, the public commonly construe a good doctor as one that possesses particular attributes, skills, knowledge, characteristics or values. On the other hand, the literature suggests that there has been a significant shift in understanding of what constitutes a good doctor over the last century. Whitehead, Hodges, and Austin (2013) argue for instance, that there has been a shift in understanding from a good doctor as being an issue of overall character, to one of discrete characteristics. In fact, it may also be argued that the discourse of *competence*, a construct that subsumes such characteristics as performance, production, knowledge and skill, is emerging and gradually displacing these other renderings (Whitehead, 2011; Leahy, Cullen, & Bury, 2003). While the emergence of the discourse of *competence* pre-dates the publication of its 1993 policy (Whitehead, Austin, & Hodges, 2013; Whitehead, 2011; Harden & Gleeson, 1979), the GMC cemented it in UK medical education when it began to put organisations under the obligation to clarify exactly how learners would be expected to demonstrate their acquisition of specified competencies before qualification (GMC, 1993, p. 14). Critically, whether by the public, in this and other related policies, or in the literature, the construct of the *good doctor* appears to boil down to an essentialist conception.

This representation can be challenged on several grounds. Firstly, patient safety is an all-encompassing term of non-specific and unclear meaning that is reminiscent of a political slogan. As I have argued above, it represents inconsistent things to different people and thus warrants clarification of its meaning. Adopting a granular approach to its definition, and specifying exactly what patient safety means in various circumstances, and perhaps re-articulating it as the *prevention of medical errors* would go a long way towards facilitating the development of structures and procedures to prevent such errors. The obvious difficulty with medical errors as a problem representation however, is that it excludes any professional misconduct that is not directly of a medical nature, such as sexual assault of patients for instance. However, it serves to clarify exactly which actions are problematic. It also crucially segregates

more clearly, yet not categorically, between harm caused to patients by agentic endeavours and that brought about by more structural issues. As the World Health Organisation (WHO) asserts, "human actions are almost always constrained and governed by factors beyond the immediate control of the individual" (WHO, 2011a, p. 100). It goes on to discourage what it views as a global tendency towards a "blame culture" (WHO, 2011a, p. 99) in health care in which individuals are fairly or unfairly pinned with the responsibility for errors, omissions and failures of care leading to patient harm. In fact, the WHO argues that the causes of patient harm arise from issues that are "personal, task-related, situational and organizational" (WHO, 2011a, p. 100).

Secondly, I would argue that patient safety is an issue that is subsidiary to the responsibility of the state to guarantee the safety, in the generic sense, of all members of society (Goldsmith, 2002). This responsibility of the state is not invalidated when an individual patient is under the care of the health service. In fact, it might be argued that since such an unwell individual is subject to greater risk of harm than others, as a result of the illness that required them to be under the care of the health service in the first place, this responsibility for their safety is heightened. Further, because the health service is a direct provision of the state, the ultimate responsibility over all patients in its care remains with the state. Actually, as Lang, Edwards, and Fleiszer (2008) argue, patient safety is a notion that has predominantly been conceived as restricted to institutional settings even though patients move into and out of those confines, in spite of an increase in the proportion of patients receiving health care in their own homes. The use of the notion of patient safety in *Promoting Excellence* (GMC, 2015c) and its predecessors falls into this discursive trap, with no mention of the unpredictability of endangerment of patients receiving care in their homes. The GMC policies therefore use an institutional and professional lens to construct the problem of patient endangerment. The problem of patient endangerment could thus be re-represented as one of failure of the state to provide adequately safe healthcare to its citizens, whether or not they are receiving institutional care.

In addition, patient endangerment may itself be the result of pre-existing preventable social problems such as poverty and drug use. It would still be the responsibility of the state to take steps to deal with these social problems in order to ensure that any patients in healthcare are not exposed to harm associated with them. Furthermore, it would be argued that the best way to prevent patient

endangerment is to ensure that people do not get unwell in the first place, to use the old adage 'prevention is better than cure'. As Woolf argues in relation to proportionality in the consideration of patient safety:

> "The issue is not whether patient safety should receive attention, as it surely must, but whether that attention is proportionate. Unless attention and resources are allocated to safety and other quality improvement areas in proportion to their relative effect on public health, an excess of the population may die or sustain morbidity" (Woolf, 2004, p. 33).

The change in focus from one of ensuring that those who are unwell are looked after in safety, to one that ensures the health and well-being of all members of society would challenge the representation of the problem as one of patient endangerment by individuals or organisations. This change in focus would also re-represent the problem as one of the (in)ability of the state to ensure that its citizens remain in the best state of health. It further represents a change in healthcare focus from therapeutic medicine to preventive public health. With the state focusing on keeping all its citizens in the best of health, and dealing with social problems such as poverty, lack of education, unemployment, and others that play a contributory role to illness, the expected result would be a reduction in number of patients and an increased ability for the health service to ensure they are kept safe.

Thirdly, patient endangerment may be the direct or indirect result of restricted availability of funding, particularly in situations of fiscal austerity. The state makes financial choices, determining what proportion and how much of their expenditure will be available to the NHS and educational organisations to fund all of their activities. The state then devolves the responsibility for determining how this money is spent, to these organisations. By devolving this responsibility, and exposing the medical education and the health service to free market dynamics, the state expects that the quality of provision will be boosted by competition and deregulation. However, the state does not provide unlimited funding to these organisations. In fact, the funding challenges facing NHS organisations have continued to increase annually (Roberts, Marshall, & Charlesworth, 2012). In addition, the availability of funding for treatments by the health service in the UK, is limited by the restrictions on spending imposed by national agencies such as National Institute for Health and Care Excellence (NICE). NICE focuses on the allocation and distribution of the state resources available to patients. Their guidance may, in certain cases, mean that

patients may not be able to receive certain treatments, purely on the basis of *cost-effectiveness*[1], whether or not this results in harm for particular patients. The funding challenges also restrict the ability of educational organisations to utilise learning and simulation technologies aimed at ensuring all learners are adequately trained and the risks of professional errors reduced. These challenges further limit the ability of educational organisations to provide adequate, suitably trained and resourced supervisors to ensure that all professional activities of learners are performed under supervision in order to reduce the risk of medical errors. The problem can thus be challenged and re-imagined as one of fiscal restrictions by the state.

By being seen to deregulate medical education and healthcare, and devolving the responsibility for the allocation of resources, the state and the GMC insidiously ensure the limitation of debate on the importance of funding as a policy problem. This achieves the aim obfuscating of the state's role in providing adequate financial resources (among other things) in the first place. The problem is thus crafted as one of the inability of organisations to ensure the fair allocation of resources, an issue of organisational ineptitude, rather than that of failure of the state to meet its moral and statutory obligations. Further, representing the problem as one of patient endangerment, by individuals primarily but less so by the organisations that teach or employ them, foregrounds the issue of individual responsibility and concomitantly restricts the possibility of discussion about the responsibilities of the state towards its citizens.

Furthermore, as illustrated in the discussion above, by underscoring the discourse of *patient safety* in its policies, the GMC implicitly privileges the practice of 'evidence-based medicine', and effectively excludes those aspects of medical education that require interpretation and interpretive practice – the art of medicine – in preference for those aspects that can be measured or that are reducible to measurable competencies (Malterud, 2001). The discourse of *patient safety* further permeates all aspects of medical education and practice, as a 'regime of truth', to the extent that all behaviour and practice is then reconstructed in terms of its relationship to 'patient safety', as opposed to their health and/or well-being. This, in fact, also proceeds from the establishment of a discourse of *risk* within a prevailing atmosphere

[1] This highly contestable and subjective notion masquerades as objective rationality, but in effect is the outcome of interdiscursivity – the discourse of enterprise influencing that of medicine (Scollon, 1998, p. 253)

of responsibilisation and the moralisation of risks. In this sense, prevention of risk is constructed as the moral responsibility of the individual, who then bears the blame for any adverse effects experienced (Liebenberg, Ungar, & Ikeda, 2015).

5.1.2 Individual responsibility

The GMC thus further represents the problem as one of individual responsibility. For instance, it asserts in the preamble of its policy in regard to the 'duties of doctors', that "you are *personally accountable* for *your* professional practice and must always be prepared to justify *your* decisions and actions" (GMC, 2015c, p. i, emphasis mine). It continues with this theme of individual responsibility throughout the policy, asserting for instance that "*learners are responsible* for their own learning" (GMC, 2015c, p. 23, emphasis mine) and "*educators are responsible* for engaging positively with training" (GMC, 2015c, p. 29, emphasis mine).

As I have already discussed above, the representation of the problem as one of individual responsibility is inextricably intertwined with that of patient endangerment, and draws significantly on the interrelated discourses of *risk* and *patient safety*. This relationship between the two representations of the problem can be seen in assertions such as "learners … must not compromise safety and care of patients by their performance, health or conduct" (GMC, 2015c, p. 23), in which the GMC explicitly links the discourses of *risk*, *patient safety* and *responsibility*. This is also a clear example of "risk individualisation" (Heyman, 2010, p. 52), by which individuals are themselves constructed as the bearers of risk, as opposed to the risk(s) being external to them. Rather than placing the focus on either representation of the problem, they are both concomitantly privileged within *Promoting Excellence* (GMC, 2015c) as though they were a singular integrated entity. For instance, the policy asserts that "educational and clinical governance must be integrated *so that learners do not pose a safety risk*, and education and training takes place in a safe environment and culture" (GMC, 2015c, p. 20, emphasis mine). This interlinkage between the discourses is further disseminated widely in the news media coverage of issues of patient harm, where questions are quite often posed as to who is *responsible* for the *suffering of a patient*, and who must thus face the consequences of *their* failure (Roberts, 2016). In fact, even when it has been identified that there are systematic or organisational issues at play, the issue foregrounded in the public eye is *who* should take

the blame (Marsh, 2016; Hitchen, 2007). As the Medical Protection Society noted in its evidence to the Health Committee of the House of Commons, "there is a *tendency to apportion individual blame* to the person who is most proximate to the adverse incident and to overlook the underlying systems failures" (Medical Protection Society [MPS], 2008, p. Ev 40, emphasis mine).

Tomorrow's Doctors (GMC, 1993) used the notion of responsibility in the sense that it referred to the duties, obligations, expectations and functions of particular roles, such as when it asserted the requirement for medical graduates to possess particular skills in "preparation for house officer responsibilities" (GMC, 1993, p. 9), as opposed to the use of the notion in terms of being the primary cause of certain, usually undesirable and reprehensible, events. The stark exception is in regard to communication skills, of which the GMC asserted "deficiencies in this area are responsible for a high proportion of complaints and misunderstandings" (GMC, 1993). While the discourse of *patient safety* had not overtly made it into this policy, it is not surprising that the policy lays the ground work for it by highlighting the issue of complaints and misunderstandings, and drawing on the emerging discourse of *risk* in relation to patient care.

By 2003 the discourse of *responsibility* was well established in *Tomorrow's Doctors* (GMC, 2003) where the GMC used the broader conception of the notion of responsibility, referring to the culpability of learners and doctors in relation to patient care as illustrated in the assertion that medical graduates should "accept the moral and ethical responsibilities involved in providing care to individual patients and communities" (GMC, 2003, p. 9). This was tantamount to furtively recruiting individuals to actively engage in, and take responsibility for, the reduction of the risks that they pose (Gray, 2009; Gray, 2005). In this policy, the GMC promoted the discourse of *responsibility* as it attempted to clearly demarcate areas of accountability of medical students, doctors and universities in relation to the protection of patients. Paradoxically, the policy does this under the section entitled *student health and conduct* (GMC, 2003, pp. 26–27); a section in which more attention and detail is given to the 'protection' of patients than the welfare of students to which the title refers.

Diachronically considering both the 2003 and 2009 versions of *Tomorrow's Doctors* (GMC, 2009, 2003), as well as other contemporaneous GMC publications supplementary to the respective policy that were a) targeted at providing more detailed 'best practice' guidance on particular aspects of medical practice,

and b) aimed at learners and doctors such as *Good Medical Practice* (GMC, 2013f, 2001), provides the clearest examples of the emergence and establishment of these aforementioned discourses. These documents are prefaced with a synopsis of the 'duties' of GMC registered doctors. The most salient distinction between the synopses however, is in their concluding phrases, where in *Tomorrow's Doctors* (GMC, 2003) and its contemporaneous publication *Good Medical Practice* (GMC, 2001), the synopses close with the same phrase: "… you must never discriminate unfairly against your patients or colleagues. *And you must always be prepared to justify your actions to them*" (GMC, 2003, p. i, emphasis mine), implicitly asserting the issue of individual responsibility. In contrast, the synopses in *Tomorrow's Doctors* (GMC, 2009) and its contemporaneous *Good Medical Practice* (GMC, 2013f) spell out the issue of individual responsibility more overtly: "*You are personally accountable* for your professional practice and must always be prepared to justify *your* decisions and actions" (GMC, 2009, p. i, emphasis mine). The rest of *Tomorrow's Doctors* (GMC, 2009) follows this trend with the notion of *responsibility* more clearly articulated with the GMC again demarcating what it views as the responsibilities of the GMC itself (2009, pp. 8-9), medical schools (2009, p. 10), NHS organisations (2009, p. 11), doctors (2009, p. 12), and students (2009, p. 13).

In the construction of individual responsibility however, individuals are viewed as rational agents who, given the freedom to choose, are capable of making the 'right' decisions for themselves and accept due responsibility for the choices that they make. As a tenet of the predominantly neo-liberal ideological position of the UK Conservative – Liberal Democrat Coalition government, under whose oversight the 2015 GMC policy was formulated, it is not surprising that individual responsibility makes such a prominent appearance in the *Promoting Excellence* (GMC, 2015c) policy. However, it is also conspicuous in the 1993, 2003, and 2009 policies formulated under the previous Conservative and New Labour governments. The Conservative governments of Margaret Thatcher and John Major were predominantly neo-liberal in their ideology. On the other hand, the New Labour governments of Tony Blair and Gordon Brown, though overtly socialist in their foundation and Centre-left in their political orientation, espoused some neo-liberal-friendly economic policies, particularly in view of the neo-liberal leaning of the 'Third Way' philosophies of these administrations. Both the New Labour 'Third way' and neo-liberal Conservative/Coalition ideologies under which the respective GMC policies were formulated and published, thus

privilege the notion of individual responsibility within the wider discourse of *responsibility* in keeping with their affinity for responsibilisation and managerialism – in which accountability, standardisation, transparency and measurable outcomes are prioritised (Park, 2012, p. 123)

Therefore, all these GMC policies were formulated in a predominantly neo-liberal environment, and it is thus unsurprising that neo-liberal ideology would undergird these policies, or that the discourse of *responsibility* would form a connecting discursive thread between these policies, and between the representations of the problems in each of the policies. The GMC, and indeed the successive UK governments, have continued to promote the idea of individual responsibility, as can easily be seen in the recent EU referendum of 2016 and the string of high profile political resignations that ensued - each individual taking responsibility for what was otherwise the democratic decision of UK society. That this is the case however, is not surprising, given the construction of UK (and perhaps global) society as a loosely bound group of discrete, rational, and thus inherently responsible individuals. Writing about the redistribution of crime control, Garland (2001) asserts that the modern state is abandoning its top down approach to social control in favour of one in which individuals are constructed as responsible for aspects of what was previously considered within the purview of the state – the responsibilising of the citizen. He argues that "the state's new strategy is not to command and control but rather to persuade and align, to organize, to ensure that other actors play their part. … individual citizens … must all be made to recognize that they have a responsibility in this regard" (Garland, 2001, p. 125). Appropriating, extrapolating and applying his argument to medical education, the responsibilisation of individual learners and doctors re-constructs the state in such a way that it alone should not be held responsible for the provision of adequate education, healthcare or welfare; and effectively jettisons these otherwise problematic (in the neo-liberal state's eyes) obligations onto individuals and organisations. In fact, on the basis of this and other studies of UK society analyses, there is a sense in which there is a coherent move towards the construction of the individual as holding to a distinct assemblage of values that accepts the consequences of one's actions; and a generic trend towards the privileging of *responsibility* and *responsibilisation* that is independent of the prevailing political ideology.

Crucially, representing the problem as one of individual responsibility does not deal with the implicit reductionism of medical practice to a definable set of skills and competencies, or the essentialisation

of the roles and identities of learners and doctors. Such reductionism and essentialisation provides the facility to measure, compare and contrast the 'performance' of individuals, rather than their actual practice – perhaps the obvious response of a leaning towards a neo-liberal positivist currency, and a hearkening to so called 'evidence-based practice' (Thomas, Burt, & Parkes, 2010). However, the reductionism serves a far more insidious purpose. It creates a focus on individuals, their actions, and their activities, and turns the lens away from the fact that structural phenomena may indeed intervene in a fashion that makes particular choices inevitable and others impossible. It further limits the ability of individuals to draw attention to, and indeed challenge, these structural phenomena. It frames the organisations, and by inference the regulator and the state, as acting impeccably and providing flawless circumstances in which to practice, and thus ascribes any blame to individual flaws and errors. To quote the Medical Protection Society yet again, "there is a *tendency to apportion individual blame* … and *to overlook the underlying systems failures*" (MPS, 2008, p. Ev 40, emphasis mine). It is proper to ask though, what role the organisations, the regulator and ultimately the state have in ensuring that patients are safe under their care; a) *who*, other than doctors or learners, b) *what* else is involved, and c) *how* else is the patient provided with high quality safe health care – thus drawing attention to structural phenomena that are important in the provision of health care.

However, the responsibilisation of the individual in *Promoting Excellence* (GMC, 2015c) does not seem to stretch as far as the patient even though this is common parlance in medical education and practice. In fact, the policy is also silent about a patient's responsibility in contributing to, and ensuring their own safety. Nevertheless, viewing the patient through the 'patient safety lens' effectively responsibilises the patient, and transfers the burden for ensuring their safety from the healthcare professional onto the patient "disenfranchising the former and overburdening the latter" (Sutton, Eborall, & Martin, 2015, p. 84). Sutton et al. (2015) also argue that such responsibilisation, effectively gives the patient the onus of both recognising and reporting any concerns in regard to their safety, without consideration of the difficulties posed by bureaucratic patient safety procedures and processes. This responsibilisation is also reflective of the influence of the discourse of *healthism* (Wiest et al., 2015; Galvin, 2002) UK society. Therefore, rather than empowering patients, such responsibilisation would have the effect of further swinging the balance of power in favour of the professional, which is more likely to result in patients deferring to the

professional in decision making, and identification of adverse effects. There is thus a precarious balance in the concept of the distribution of responsibilities in the health care setting, with greater emphasis being placed on doctors responsibilities than those of patients (Kelley, 2005). However, that a patient bears some, even though minimal, responsibility for his/her own wellbeing and health care is taken for granted. As Vincent and Coulter (2002) argue, patients play a key participatory role in their own care in which they help to ensure that healthcare professionals are enabled to provide them with the best service. This responsibility however, is often incorrectly viewed as ending when the individual comes under the care of the health service, and thus silences any critique of the patient if and when issues regarding their care arise whilst in the care of learners and doctors. While the silence on the responsibility of the patient in *Promoting Excellence* (GMC, 2015c) is notable, it is by no means surprising given the fact that since the emergence of the medical profession, medical ethics and professionalism have placed far more emphasis on the responsibility of doctors; the paternalistic underpinnings being tempered by a more silent recognition of patients rights. Nevertheless, the responsibilisation of the patient is merely an extrapolated application of the discourse of *responsibility*, and stands to further obfuscate the necessity of the role of the state in providing healthcare.

As I have argued in my discussion of the 'problem' of patient endangerment above, what is hidden in plain sight by the representation of the problem as one of individual responsibility, is the fact that patient harm is not solely due to actions of individuals in the workforce (Daker-White et al., 2015), and that it may also be the result of structural phenomena such as the environmental, cultural and professional conditions in which the patients are looked after, as well as the treatments they are given. Representing the problem as one of individual responsibility has the effect of discursively sequestering learners and doctors from their professional environment, and thus obfuscates the fact that they do not practice in such isolation. The problem could thus be rethought as an issue of the structural phenomena, intrinsic to medical education and the health service, that limit the options available to individuals. To illustrate this further, a predicament frequently reported in the media is that of patients being subjected to long waiting hours in NHS Emergency departments, as a result of the unavailability of inpatient beds for admission of such new patients. This effective shortage of beds is quite commonly the result of delays in discharging existing patients because of difficulties in ensuring the availability of suitable social care (Thompson &

Turner-Warwick, 2016). Harm visited upon patients as a result of such delays, and the resulting limits applied to the ability of a learner or doctor to admit a patient should not then be the responsibility of the individual. In fact, the response to issues of *unintentional* patient harm in some western countries has not been to assign blame to individuals, but to place the emphasis on learning from mistakes made, and putting in place systems and procedures to ensure that the mistakes do not happen again (Svansoe, 2013). What this goes to show is that the problem can be disrupted and re-represented as one of structural failures for which systemic measures can be applied.

Nevertheless, *Promoting Excellence* (GMC, 2015c) is also silent on which roles, duties and responsibilities the state holds, particularly in regard to patient safety. The controversy here is whether it is the individual's responsibility to ensure their own safety and well-being, both in and out of the medical education/health care environment, or if it is the duty of the state and its organs. One's perspective of this controversy would depend upon which side of the political divide they were, with those on the far left viewing it as the state's exclusive role, and those on the far right ascribing the responsibility to the individual. By representing the problem as one of individual responsibility however, the spotlight is taken away from the state's own duty to ensure the health and welfare of all its citizens. However, it could be argued that the problem would be more logically represented as the outcome of restrictions and reductions in state funding of health, social care and welfare rather than one of individual responsibility. In fact, it is public knowledge that the financial demand placed on the NHS far outstrips the availability of funds (Thompson & Turner-Warwick, 2016). In view of the intricate relationship between the NHS and medical education, any financial limitations on the former directly affect the latter. In fact, looking more closely at the state of medical education funding, the problem could equally be rethought as a fiscal one relating to the distribution of financial resources between education organisations and the NHS. Funds thus redirected from healthcare to medical education may indeed be unavailable to ensure the safety of patients. Likewise, redirection of funds from medical education to health care directly impacts the ability of educational organisations to adequately fund their pedagogic and scholarly activities.

In a health service facing reduced funding relative to its expenditure (Roberts, Marshall, & Charlesworth, 2012), it would appear both logical and rational that service provision has to take priority over education and training. However, *Promoting Excellence* (GMC, 2015c) itself is silent in regard to the balance of

resourcing between the NHS and education. The policy asserts for instance, that Local Education Providers (LEPs)[2] "… are accountable" (GMC, 2015c, p. 8) for the disbursement of resources for medical education, but no mention is made as to the source of these resources, or as to how the distribution of these resources between the LEPs and the health service would be managed. In fact, it is left up to individual LEPs to choose exactly how resources are disbursed, in a free market economy in which competition is seen as desirable, and it is not even clear how these resources are subsequently utilised by the LEPs (BMA, 2007). This implicitly represents the problem as one of responsibility of organisations – an extrapolation of the notion of *responsibilisation* in one sense, and an application of free market principles in the other. This also implies the devolution of responsibility from the state and the regulator; the devolution being promoted as beneficial to LEPs, in the sense that it is empowering, and that it gives them the flexibility to determine how best to utilise the resources provided to them without undue interference by the state.

However, this devolution means that the distribution of resources by individual LEPs is not standardised, uniform or transparent across the sector, and the resulting variation in provision of resources for education and training inevitably means that some learners will get a poor (or relatively poorer) learning experience. Differential resource disbursement, especially in the light of a focus on patient safety, may quite often mean reduction in resources for education and training. Learners are thus left dependent on the priorities of LEPs, and it is indeed conceivable that learning can be interrupted in order to facilitate the distribution of resources to health service provision elsewhere. This precarious balance between education/training and patient care drives compromises to the detriment of both rather than driving improvements. This unfortunately means that there will be, and indeed are, reduced education and training opportunities for learners, as well as and increase in potential risks to patients. The reduction in opportunities to learn is related to increases in the likelihood of harm being visited upon patients by poorly trained and under-experienced learners and doctors. However, there is poor evidence in the literature of a distinct effect either way, on both patient safety and medical education (Moonesinghe, Lowery, Shahi, Millen, & Beard, 2011). In spite of the lack of supportive evidence in the literature, the use of modern technology where this is feasible, to make up for anticipated deficiencies in the provision

[2] "Local Education Providers" is a catch-all term used by the GMC to identify those organisations that provide medical education and training, including NHS trusts and General Practitioner (GP) practices (Marchant, 2013)

of education and training opportunities, and to reduce the risks to patient care associated with reduced experience of learners and doctors, is on the increase (Ziv et al., 2000). This also means that, because the risks of incidental harm to patients are thought to reduce as doctors get more experienced, there is a move toward the delivery of health services by consultants and other experienced, fully qualified doctors (Edwards, 2012). This move to consultant or specialist-led services however, has the unfortunate effect of further reducing the opportunities for the education and training of learners, and thus presents a long-term risk to the availability of suitably skilled and experienced doctors.

Representing the problem as one of responsibility, a key feature of neo-liberal ideology (Cradock, 2007; Thompson, 2007), narrows the focus of any deliberation from the state to the organisation and individual, rendering the state conceptually invisible – foregrounding responsibilisation and the discourse of *responsibility* privileges those phenomena that are constructed as responsible and trivialises those, like the state and the GMC in this instance, which are constructed as not bearing (significant) responsibility in any particular context. This trivialisation of what would be envisaged as the responsibilities of the state and its organs further provides the state with the ideological space to introduce and reinforce other aspects of its neo-liberal agenda, such as the application of free market economics to medical education; concomitantly silencing any challenges from those individuals and organisations thus constructed as bearing the responsibility. Unfortunately, the variation in provision as a result of competition, market dynamics, and lack of synchronisation in education means that some learners will invariably receive a poor (or poorer) learning experience.

Thus, as I have already argued above, in keeping with the interlinked discourses of *responsibility* and *patient safety* in the healthcare setting, the problem can also be rethought as an issue of patient welfare, implying a collective responsibility, with the GMC and the UK government responsible for ensuring that health care in the generic sense, not just patient care, is availed to society. This would increase the scope of coverage of policy measures and proposals in relation to patient welfare, beyond the confines of NHS institutions to all locations and situations in which individuals would require medical attention. One would ask for instance, whether all preventable factors leading to disease, such as poverty, the use of addictive substances, lack of (or poor) education and poor social welfare, are dealt with at source to ensure a reduction in the incidence of disease, and thus reduce or remove the need for individuals to

seek medical attention? In fact, a mere change to the phrasing of the policy to emphasise that learners and doctors work *together* with patients, the GMC, the NHS and Government to ensure that there are no issues that would impinge on their (patients') well-being, would draw attention to the wider ramifications of this issue.

Further, re-constructing the problem as primarily one of structure and structural failings removes the emphasis from the actions of individuals in isolation from their environment. Nevertheless, rethinking and re-representing the problem in an effective manner also requires that medical education, and the medical profession as a whole, challenge the now taken for granted focus of medical practice on making ill people better, and replace it with an emphasis on societal health and the prevention of illness in the first place. It requires educators to look critically at all taken for granted discourses that have become normal currency in medical education with the aim of challenging these self-evident regimes of truth and replacing them with alternatives that benefit society as a whole, rather than merely meet state targets. As Bourdieu argued "Everywhere we here it said, all day long – and this is what gives the dominant discourse its strength – that there is nothing to put forward in opposition to the neo-liberal view, that it has succeeded in presenting itself as self-evident, that there is no alternative" (Bourdieu, 1998, p. 29). Such a change in focus then makes healthcare an issue of state provision, in its role as advocate for healthcare for all its citizens.

5.2 Problem education

Building on the aforementioned problem representations, and on the discourses of *patient safety* and *responsibility*, *Promoting Excellence* (GMC, 2015c) further represents the problem as one of *problem education*. This is an overarching representation which subsumes the principal policy 'subproblems' of: a) problem learning environments, and b) problem curricula each of which I will discuss separately below.

5.2.1 Problem learning environments

In articulating the primacy of patient safety to *Promoting Excellence* (GMC, 2015c), the GMC depicts the assurance of the welfare of patients as integral to the medical learning environment, asserting that "patient safety is inseparable from a good learning environment" (GMC, 2015c, p. 5). By making this explicit assertion, and in keeping with the privileging of the discourse of *patient safety* in the policies and publications of the GMC, and the resulting tendency in UK medical education to construct identities, interactions and functions through a '*patient safety* lens', the *Promoting Excellence* (GMC, 2015c) policy subtly signals a change in focus from the risks posed to patients as a result of learners' *actions*, to an emphasis on risks emerging from *exposure to the learning environment*. The problem is thus represented as one of 'problem learning environments'. This representation is primarily dependent on a view, looking through a *patient safety lens*, that constructs medical education and training as potentially unsafe for patients, that assumes that the medical learning environment cannot therefore be guaranteed free of errors, adverse effects, or other inherent risks to the safety of patients. It thus demands that preventive measures be taken, by individuals and organisations, to mitigate against this presumed lack of safety. The challenge here is that by definition, a good learning environment is one that affords plenty of opportunities for a learner to practice; practice in this sense being suggestive of rehearsal and the gradual development of expertise, as opposed to the expert pursuit of a profession.

Drawing on the implicit framing of competition in UK medical education as desirable, the representation of the problem as one of 'problem learning environments' is promoted and disseminated by the higher education sector adherence to the publication of league tables, such as the National Student Survey (HEFCE, 2016), University or Medical School Rankings (Times Higher Education, 2016), and other similar measures of educational 'standards' and desirability. In addition, this representation of the problem does not take into consideration the fact that the greater proportion of medical education and training occurs in organisations whose primary purpose is the provision of healthcare and not education. These organisations, including the medical and surgical colleges, faculties and clinical speciality associations across the UK, the Local Education and Training Board (LETB)s in England, Postgraduate Deaneries in Northern Ireland, Scotland and Wales, and medical schools across the UK leverage contracts and

agreements with LEPs to ensure the provision of suitable learning environments for undergraduate and postgraduate medical education. They receive funding primarily from the state for health care and medical education (BMA, 2007), with the state insidiously framing this financial provision as its only involvement in medical education. Organisations are then driven by fear of punitive action, including the restriction of the flow of funding from the state, to meet these requirements. Failure to meet them means loss of licence to operate or other regulatory action. Representing the problem as one of responsibility thus serves the purpose of distancing the state from these organisations; promotes the devolution of responsibility away from the state and the GMC to organisations; and facilitates the promotion of a free market economy, and the privileging of 'competition' in medical education.

Looking back at the emergence and establishment of this problem representation, in its *Tomorrow's Doctors* (GMC, 1993) policy, the GMC did not make any proposals in regard to the learning environment, nor did it use the term at all, in spite of the fact that a) the GMC itself insisted that medical education be "informed by modern educational theory", and b) the term was in common usage in the educational literature well before the publication of the policy (Entwistle, 1991; Bossing, 1952). By 2003 however, even though the term 'learning environment' was not used explicitly, *Tomorrow's Doctors* (GMC, 2003) did make specific proposals in regard to it, asserting the requirement for all medical schools to provide students with "appropriate learning resources and facilities" and "an appropriate environment (where they are supported by teachers) before they use these skills in clinical situations" (GMC, 2003, p. 20). These proposals presumed the ability of medical schools to ensure that such learning facilities and resources were provided for students both within the medical schools themselves, and in NHS facilities, which were out of the explicit control of the schools. Nevertheless, implicit in the assertion that students had opportunity to practice skills outside of the patient setting, and "before they use these in clinical situations" is the insertion of the discourse of *patient safety* into the learning environment. Arguably, some forms of learning may be better done, and the required expertise gained (in keeping with the discourse of *patient safety*) in non-patient environments, before the learners are granted access to patients (McGaghie, Issenberg, Cohen, Barsuk, & Wayne, 2011). However, this view of learning through the *patient safety lens* restricts the opportunities available for learners to acquire the knowledge and skills that would be essential to their future practice.

In a similar vein, *Tomorrow's Doctors* (GMC, 2009) did not use the term 'learning environments' but still articulated the requirement for the provision of facilities and resources for learning by medical schools, utilising the same phrases from the previous policy but additionally asserting that "learning in an environment that is committed to care, based on evidence and research, can help medical students to understand the importance of developing research and audit skills to improve their practice" (GMC, 2009, p. 74). By this time however, the explicit amalgamation of research and 'evidence' into the medical learning environment signalled the move towards the essentialisation of medical education, and the reductionism applied to the identities and roles of learners and doctors – all parts of the tendency towards being able to measure and manage individuals that is typical of neo-liberal thought.

In spite of this rich history of the development of the representation of the problem, while *Promoting Excellence* (GMC, 2015c) explicitly asserts a move away from a focus on patient endangerment as a result of medical errors consequent to the actions of learners, it still overtly articulates the need for organisations to put in place mechanisms to facilitate whistleblowing on issues of patient safety. It asserts that organisations "must demonstrate a culture that *allows* learners and educators *to raise concerns about patient safety*, and the standard of care or of education and training, *openly and safely without fear of adverse consequences*" (GMC, 2015c, p. 10, emphasis mine). Therefore, while on the one hand the policy purports to change its focus away from patient endangerment in regard to learner's actions, it in fact re-emphasises and reinforces its primacy as a representation of the problem. With this assertion however, the policy implicitly scaffolds organisations into providing and maintaining a means by which the regulator can maintain a constant gaze over medical education and practice,. It thus facilitates the production of a panoptic culture, and creates "a state of conscious and permanent visibility that assures the automatic functioning of power" (Foucault, 1995, p. 201), which in turn enables the establishment and maintenance of regulator control over the organisations without necessitating an increase in the size of government – an approach to 'governing at a distance' (Rose & Miller, 1992). This drive towards panopticism (Foucault, 1995) thus paradoxically facilitates the simultaneous imposition of neo-liberal decentralisation, as well as the central control typical of socialist ideology.

The representation of the problem as an issue of 'problem learning environments' draws on the assumption that when faced with restricted funding, organisations make choices in regard to the resourcing of

learning environments, balancing the need to fund these as well as other healthcare activities that may hold more value to the organisations, and may thus mean that the environments are not adequately resourced. It reflects the current state of affairs in which medical education and training is subservient to patient care both in declared value, and the extent of funding/resourcing as far as the increasingly decentralised NHS is concerned (Chan, 2015). In fact, the NHS's own articulation of its core principles and values shows the expected predominance of health care related statements, but a striking lack of an articulation of values and principles to do with medical education (National Health Service [NHS], 2016). It could be argued that the NHS is first and foremost a *health* service, which must prioritise the provision of health care, and is not necessarily equipped, nor was it envisioned, primarily as a provider of education. It also exposes the hidden conflict between movement towards the decentralisation of medical education on one hand, and the maintenance of central (GMC) control, in which centralisation is favourable for the valuing of education, whilst decentralisation is ambivalent. This further reflects the ongoing dissension between the socialist foundation of the UK national health service (Powell, 1997), and more recent neo-liberal approaches to the provision of healthcare and medical education. The undervaluing of learning and learners is self-propagating when taken in tandem with other problems such as the potential of risks to patient safety. When organisations are faced with the choice between ensuring patient safety, an issue for which there is wide media coverage, a financial incentive and significant regulatory activity (by the Care Quality Commission and the Human Tissue Authority for example) on one hand, and education and training for which there is significantly less funding and sparse regulatory activity on the other, they are given a firm incentive to prioritise healthcare as opposed to education. Further, because health care is a multidisciplinary undertaking that typically involves many different health professionals, other than doctors, that are not directly regulated by the GMC, the thrust of the policy over *all* the educational activities of the NHS is undermined, and it thus has to be aimed at those over which it has the regulatory powers i.e. the learners, doctors and educational organisations.

The issue of 'problem learning environments' is also fundamentally one of responsibility. *Promoting Excellence* (GMC, 2015c) asserts that organisations "… are accountable for how they use the resources they receive to support medical education and training. *They are responsible* for taking action when concerns are raised that impact on patient safety" (GMC, 2015c, p. 8, emphasis mine). Nevertheless, this

representation of the problem fails to recognise the possibility of conflict between the need to provide healthcare on one hand, and medical education on the other. There are many circumstances where the provision of medical education and training may be in conflict with the need to ensure patient safety. For instance, it is indisputable that it is in the best interests of the learner and practitioner that they get the opportunity to gain as much practical experience as possible in the conduct of clinical procedures. These opportunities to gain experience are essential for the development of expertise. In addition, for the purposes of authenticity of the learning situation, this experience is best gained in real life contexts with and on patients. However, patient safety is often contingent on ensuring that all those treating them (learners and doctors) have had adequate practical experience and gained fluency and expertise *before* performing such procedures on them (Chiong, 2007). There is thus established, a self-perpetuating vicious cycle in which learners are unable to gain adequate, authentic experience because of concerns of risks to patient safety, and patients are put at increased risk of harm when they receive care from learners and doctors who lack this otherwise essential experience. This has led to a situation where, in the last couple of decades, with the promotion of patient safety and individual responsibility in healthcare, learners have had a perpetually reducing range of opportunities to gain the clinical experience that is critical for their training, and for the development of the expertise that is essential for reducing the likelihood of harm to patients (McManus, Richards, Winder, Sproston, & Vincent, 1993; Zenz, Osterberg, & Kraft, 1998). In this sense therefore, that which is beneficial for patients is detrimental to learners.

The fiscal subservience of the learning environment is also of particular concern. Without the required funding, learning environments cannot be brought or kept up to standard, especially when the standards are themselves subject to rapid change. In addition, because the learning environment for medical education spans multiple institutions, each with its own fiscal needs, governance, infrastructure and facilities, it is practically impossible for individual educational organisations to adequately determine, control and distribute the financial resources required by each separate institution in order to ensure the provision of a particular quality of learning environments.

In effect, representing the problem as one of 'problem learning environments', makes the assumption that it is possible for medical schools, as the formative provider of medical education, to singularly determine their quality, but is simultaneously imperceptive to the implications it has on the variety

of other education providers. In fact, with organisations free to decide where, by what means, and to whom they distribute resources, especially in the light of a concomitant prioritisation of patient safety, education and training are placed at risk of receiving insufficient resources to provide suitable learning environments. This creates a vicious cycle in which the quality and suitability of learning environments are thus left dependent on the interests of these organisations, and the precarious balance between education/training on one hand and patient care on the other drives compromise in both, as opposed to raising standards. Therefore, the representation of the problem as one of 'problem learning environments' can be challenged on the grounds that it is in essence a financial problem, an issue of the funding and resourcing of organisations for education and training, and re-representing it as such.

Ultimately however, this representation of the problem cannot be reliably disrupted and challenged without simultaneously challenging a) the application of neo-liberal ideology such as free market dynamics to the provision of healthcare and education – social services that are ultimately the responsibility of the state, and the right of every citizen, b) the responsibilisation of the learner/doctor/patient in regard to the health and welfare of the individual, c) the view of healthcare and medical education through a patient safety lens, and d) the responsibilisation of organisations in regard to the provision of learning environments and the disbursement of state-provided resources.

5.2.2 Problem curricula

Promoting Excellence (GMC, 2015c) demands that a wide variety of people be involved in the development of medical school curricula including learners, "educators, employers, other health and social care professionals and patients, families and carers" (GMC, 2015c, p. 33). In contrast, the preceding *Tomorrow's Doctors* (GMC, 2009, 2003, 1993) policies do not prescribe the kinds of people that need be involved in curriculum development. However, by proposing to prescribe the involvement of people in curriculum development as a remedy, the policy represents the problem as one of 'problem curricula'. The policy frames these as curricula that are not constructed by an all-embracing assortment of those individuals, professionals, and groups involved in any aspect of healthcare and medical education. Curricula are thus

judged, not on the basis of their academic quality, but rather on the basis of *who* was involved in their development.

A large proportion of the text of the previous *Tomorrow's Doctors* (GMC, 2009, 2003, 1993) policies was, in fact, curriculum material that described the desired outcomes of medical education. Since the publication of *Promoting Excellence* (GMC, 2015c), this curricular content is published separately from the main policy in two volumes: *Outcomes for graduates (Tomorrow's Doctors)* (GMC, 2015a) and *Outcomes for provisionally registered doctors with a licence to practise (The Trainee Doctor)* (GMC, 2015b). These separate curricular documents are still disseminated by the GMC, together with *Promoting Excellence* (GMC, 2015c), as part of what they promote as their (conceptually) singular policy for medical education and training (GMC, 2013d). *Promoting Excellence* (GMC, 2015c) is far more prescriptive in regard to curricula than its predecessors, articulating a list of eight key activities and opportunities that medical school curricula are obliged to offer their students, and constructing bad curricula as those which are poorly aligned with its requirements. Introducing its theme on curricula for instance, this most recent policy asserts that the theme is essentially "about making sure medical school and postgraduate curricula and assessments are developed and implemented *to meet GMC outcome or approval requirements*" (GMC, 2015c, p. 31, emphasis mine). Organisations are thus expected to demonstrate how each portion of their own medical curriculum maps against the GMC's outcomes in this curricular document. This representation of the problem therefore makes the necessary assumption that the GMC curriculum itself, as the 'gold standard' reference, stands up to educational scrutiny and its requirements are necessarily compliant with good educational practice.

Nonetheless, the representation of the problem as one of 'problem curricula' has a long history in UK medical education policy, even though it has been, and is being articulated has changed significantly. In *Tomorrow's Doctors* 1993 (GMC, 1993) for instance, the GMC bemoaned what it saw as the long history of non-compliance of organisations with its previous policies, asserting that there was a "persistent gap between the good intentions of successive Councils and the implementation of their Recommendations" (GMC, 1993, p. 5). The GMC put the blame for this non-compliance on the evolution of medical education from an apprenticeship, and on the failure of successive legislation to grant it sufficient powers to enforce its policies and to remedy what it saw as the deficiencies of medical curricula.

At first glance, the insistence that the development of organisations' medical curricula involve a large variety of individuals appears to be aimed at fostering inclusion, as well as a drive towards equality and diversity – the comprehensive involvement ensuring that all interests are served equally. However, the devolution of the development of curricula away from the GMC to organisations, and the freedom that this devolution has granted to organisations to develop their own distinctive curricula, in line with the GMC's requirements yet without their explicit central control, means that organisations are able to document the involvement of certain individuals and groups, perhaps privileged, appointed or otherwise chosen by way of tokenism and cronyism, in the development of their curricula. Ultimately, the fact that these curricula are not rigidly correlated to that of the GMC, means that organisations are still able to demonstrate their distinctiveness in their curricula, and thus foster competition between organisations.

To illustrate this latter point anecdotally, in my own involvement in recruitment activities for the medical school, a question I am frequently asked by prospective applicants and their parents is "*how do you teach anatomy in the medical school, do you use whole-body dissection or prosections?*". As illustrated by this question, UK medical schools do not necessarily provide the same (or similar) resources, content and learning environments to their students (McLachlan, Bligh, Bradley, & Searle, 2004). The foundation of this question is based on the fact that, in the current era of the application of free market policies in medical education, organisations are free choose to develop distinctive approaches to learning and curricula, in order to market themselves, distinguish themselves from each other, and compete for both students and staff. In view of the development of medical curricula in isolation from those of other organisations, such distinctiveness means that competition and free market economics still play a significant role in curricular development. Here, competition between medical schools is framed as desirable – in the sense of the neo-liberal free marketplace where vendors (medical schools) depend on differentiation and competition in order to guarantee they would sell their commodities. In addition, the reticence of the GMC to impose standardised qualification examinations upon UK medical schools in spite of the will to do so (Kaffash, 2014), means this fragmentation is still being propagated, and competition implicitly encouraged. However, the *Promoting Excellence* (GMC, 2015c) policy is silent on the propagation of this fragmentation, especially by medical schools of elite progeny with a reputation and expectations to protect.

However, I would argue that the GMC was in some ways complicit in the propagation of the fragmentation of medical education in its overt moves to create "diversity between medical schools" and "expression of *individuality* and the *competitiveness* of medical schools" (GMC, 1993, p. 8, emphasis mine). The *Tomorrow's Doctors* (GMC, 1993) policy drew on the findings of the *Merrison Report* (Merrison, 1975) to argue that the inclusion of a pre-registration year subsequent to graduation from medical school had been a failure even though its aims were well founded. The GMC argued that there was still a perception, among both educators and employers, that medical education was otherwise unable to provide newly qualified doctors that possessed all the requisite knowledge and skills to practice safely. However, it decried a) the attempts to ameliorate this by making medical curricula more comprehensive, b) the tendency of "quasi-autonomous" (GMC, 1993, p. 6) departments to surrender curricular time, and c) the "excessive enthusiasm of teachers for their own subject" (GMC, 1993, p. 6). The GMC argued that the remedy would be the removal of some of the core "factual learning" (GMC, 1993, p. 6) from undergraduate curricula, under the assumption that it would be taken up by postgraduate training.

Sir Donald Irvine (2006), a former President of the GMC, also highlighted the role of influential organisations in resisting its efforts to universally implement its recommendations, and choosing to maintain their own distinctive curricula. As he asserted "the leaders of the Royal Colleges, the university medical schools and the BMA were the real power brokers. From its first days the GMC adopted a passive, narrow role, doing what the medical corporations allowed or wished it to do" (Irvine, 2006, p. 204). Essentially, he noted that the fragmentation of UK medical education that had existed right from its inception had continued to plague it well into the 1990s. Implicit in the assertions of the GMC and of Sir Irvine above however, is the recognition that the use of its curriculum and policy(ies) was an effective means for the GMC to exercise its power over medical education.

5.2.2.1 Power in the curriculum

In respect to exercising power through the medical curriculum, the GMC overtly articulated its aim to "promote the development of a curriculum which corrects the existing faults of overload and didacticism" (GMC, 1993, p. 6). By dealing concurrently in this assertion with the issues of the academic workload for

learners, and the pedagogical method used, the policy shone the spotlight on medical schools, where the focus had always been on teachers imparting the sum total of medical knowledge to the student (Freire, 2000). While this didactic method might have been viewed as laudable at the time, by highlighting it, *Tomorrow's Doctors* (GMC, 1993) in particular, and to a less obvious extent its successors, represented the problem as one of power/knowledge in the curriculum; an issue rooted in power relations involving what was viewed by the GMC as the unfair exercise of power by medical schools and teachers over students.

In this policy, the GMC constructed this problem representation as arising from the erstwhile division of the medical curriculum into discrete subject areas, and the resulting autonomy of influential departments based around these subject areas. Such disciplinary autonomy has been an integral part of the composition of higher education, since time immemorial, with entire departments built around subject specialisms. A line was therefore drawn in the sand by the GMC, insofar as the exercise of power in medical education was concerned, to make it clear that it was no longer perceived as acceptable for subject experts as teachers, to wield such power over medical students. Fore-telling the forthcoming changes to UK medical education, the GMC asserted:

> "courses based on departmental disciplines are likely to be abandoned in favour of those relating to systems of the body or topics of relevance to the overall scope of the course. We strongly favour true integration of the course, both horizontal and vertical, using the term in the sense of interdisciplinary synthesis and not simply coordination or synchronisation of departmentally based components" (GMC, 1993, p. 8).

The GMC thus proposed significant modifications to medical curricula resulting in the erosion of distinct subject boundary lines. This then culminated in moves by medical schools away from traditional curricula towards those based on constructivist and student-led approaches to learning, and the emergence of integrated curricula (Harden, Davis, & Crosby, 1997).

Further, by seeking to control who wields power in the curriculum, the effect of representing the problem this way resulted in changes in the identity of medical teachers; moving away from 'subject experts' towards 'medical education experts' (Hu et al., 2015), and implicitly introducing the identity or subjectivity of *medical educators* as I discuss in section 5.3.3. It also had the effect of driving changes

in the content of the medical sciences, with greater emphasis being placed on those aspects that had demonstrable clinical relevance and application; the suppression of any esoteric aspects of the sciences; and the gradual transmogrification of assessment in medical curricula away from tests of knowledge recall towards tests of knowledge application.

Representing the problem as one of power/knowledge in curricula, drove curriculum delivery further away from methods such as the plenary lecture, the mainstay of higher education, towards student-centred approaches where it was the ability of the students to learn the material presented that determined how much information was presented. The exercise of power thus changed hands with students being granted greater say in their education. The outcome of this change of hands has been the introduction of student representation at all levels of academic administration – beneficially resulting in the social inclusion and empowerment of students. In addition however, particularly as a result of the introduction of tuition fees for higher (and medical) education in the UK, there has been a shift in educational focus towards a consumer model. An educational model in which the consumer (student) both expects and demands a prescribed value for their money. These changes further led to an overall reduction in employment opportunities for subject specialists, and a concomitant reduction in the number and availability of university courses leading to qualifications in these specialist subjects. This decline is evidenced by the ongoing dwindling of basic science research in medical literature (Steinberg et al., 2016).

Further, the representation of the problem as one of the exercise of power in the curriculum, the emphasis on social inclusion, the turn away from the elitist structures that once graced its walls, as well as the drive for social accountability has driven the medical curriculum away from a focus on *excellence* to a focus on *competence*. This represents a move away from *subject mastery* towards the *mastery of learning* in the generic sense, and development of the skills and attitudes of adaptability.

Exercising power through the medium of the medical curriculum however, offered the GMC the unique opportunity to shape the identity and the subjectivities (Bleakley et al., 2011, p. 29) of the learners, educators and the medical profession as a whole to fit the GMC's, and by extension the state's, neo-liberal agenda. As the GMC asserted in 2003, "the undergraduate curriculum … *provides a foundation for*

future learning and practice" (GMC, 2003, p. 4, emphasis mine). Such exercise of power was recognised as essential for establishing control over the medical profession, and power which at the time they did not have the authority to exercise. In addition, compared to other educational settings, the exercise of power by the GMC in the medical curriculum is construed as absolute. This leaves organisations and educators without the ability or facility to make significant changes to aspects of the curriculum in order to facilitate learning and related purposes. As Webb (2002) notes, educators in other educational settings may often wield power to make alterations to prescribed curricula in order to foster learning by the use of "teacher power" (Webb, 2002, p. 47). In contrast, the GMC constructs their curriculum as inviolable, and exercises its power to impose it upon medical education by the use of a regulatory regime of site visits, information submissions and the threat of the loss of the authority to grant registrable medical qualifications.

Building on the construction of the medical curriculum as a mechanism for the exercise of power, the GMC drew upon the discourse of *responsibility* in the re-articulation of this problem representation in subsequent policies, asserting that "universities are responsible for … providing a curriculum that will deliver the learning outcomes that we set" (GMC, 2003, p. 25) and "medical schools are responsible for … providing a curriculum and associated assessments that meet: i. the standards and outcomes in Tomorrow's Doctors, ii. the requirements of the EU Medical Directive" (GMC, 2009, p. 10).

In light of the above discussion, I would argue that the representation of the problem can be challenged and disrupted by re-representing it as an issue of decentralisation and devolution, in other words, an issue of the application of the neo-liberal agenda to the delivery of medical education. Resistance to the application of this agenda in medical education, by the re-casting of medical education as a social issue inextricably linked to the basic human right of health, and thus a core responsibility of the state, would facilitate the challenge and replacement of this representation of the problem.

5.3 Problem individuals

Building on the discourses of *responsibility* and *patient safety*, *Promoting Excellence* (GMC, 2015c) further represents the problem as one of 'problem individuals'. This representation of the problem as one of

'problem individuals' is not unique to medical education policy. Walton (2010) for instance, in his policy archaeological study of anti-bullying policies in schools, found that such policies focused exclusively on the behaviour of certain problem individuals, and as a result redirected the focus away from (and constrained any engagement with) social issues related to violence in schools such as differences in race, class and gender. However, the peculiarity of the problem representation in *Promoting Excellence* (GMC, 2015c) is that it constructs it as comprising the representational sub-categories of 'incompetent learners', 'substandard learners', and 'substandard educators'.

5.3.1 Incompetent learners

Promoting Excellence (GMC, 2015c) constructs the problem of incompetent learners on the basis of the quality of the health care service they provide, emphasising the need for such learners to be assigned tasks commensurate to their level of education and expertise. This is in contrast to other understandings of the notion of 'problem learners' where the emphasis is generally on the ability of the individual to successfully meet educational requirements. For instance, Steinert (2013) describes such individuals as "a student or resident who does not meet the expectations of the training program because of a significant problem with knowledge, attitudes or skills" (Steinert, 2013, e1035-e1036). In *Promoting Excellence* (GMC, 2015c) however, the 'problem' is further represented as being derived from the issues of *patient endangerment*, *individual responsibility* and *resource distribution* as discussed above. In this representation, the supervisors of these incompetent learners are perceived as being responsible for the patient harm caused by the errors and omissions of the learners, and the lack of suitable supervision of these learners conceived as an issue of resource distribution and thus the responsibility of organisations. Further, in a health service under increasing strain both in fiscal and resource terms, learners are left marginalised, or perhaps assigned routine and less 'risky' duties that may not necessarily be useful for learning, but otherwise crucial to contribute to bearing the overall workload of the health service in order to meet state targets. Learners are also often faced with the possibility that their education and training can be disrupted or interrupted in order to facilitate resource distribution elsewhere as the health service demands. This representation of the problem thus draws on neo-liberal assumptions to the effect that

it is up to individuals or organisations, acting in a free marketplace, to choose how to distribute the resources available to them without interference from the state, and importantly, to take responsibility for their actions.

This problem representation also draws on the dominant discourses of *competence* in medical education (Whitehead, Austin, & Hodges, 2013; Hodges, 2012), propagating a dichotomy of the competent, constructed as 'safe' learners and doctors, as opposed to the incompetent, who are those constructed as 'unsafe'. Further, with medical education predominantly viewed through a 'patient safety lens', representing the problem as one of 'incompetent learners' has the effect of implicitly constructing all learners as a safety risk, since by definition the learner does not possess the experience or expertise of the qualified doctor. Incongruously, *Promoting Excellence* (GMC, 2015c) overtly purports to have moved away from a risk-laden view of learners, asserting: "where our standards previously focused on protecting patients from any risk posed by medical students and doctors in training, we will now make sure that education and training takes place where patients are safe …" (GMC, 2015c, p. 5). This representation of the problem means however, that learners are more-or-less automatically denied adequate opportunities to gain valuable experience because of the perceived risk to patients from whom they would gain such experience. It also means that where there are medical errors, the blame is so easily placed on learners. Representing the problem as such also effectively closes off the ability to consider that competence is not an all-or-none issue, but a continuum in which one gets more and more competent by virtue of experience.

Drawing on the discourse of *competence* also means that learners and doctors are faced with a reductionist approach to their identity, role and practice. Learners and doctors are constructed as competent on the basis of successful completion of measurable and reproducible tasks; a mere tick-box exercise in effect, but one which plays into the neo-liberal preoccupation with measurement and management.

The representation of the problem is promoted and disseminated in the news media and in the literature, where the coverage of medical errors, and the explicit linking of the harm caused to patients to the lack of competence of the learner or doctor concerned, results in the vilification of learners (BBC, 2006). Even more recently, the UK Government has participated in the propagation of the representation of

the problem by the publication of *evidence* to the effect that patients are at increased risk of harm at the weekends when in the care of learners and often without supervision (Wise, 2016; Hunt, 2015; Freemantle et al., 2012). However, the problem can be rethought as one of the inability of the state to ensure an adequate supply of suitably qualified doctors, in order to ensure the safe delivery of healthcare, the provision of high quality medical education, and the assurance of adequate supervision of learning. In fact, the state itself has also represented this as a fiscal issue by challenging the need to pay learners extra for work done at weekends in so called "unsociable hours" (BBC, 2016). Incongruously, as the main source of funding for healthcare, the state implicitly points the finger to itself as the source of the problem by representing it as a fiscal issue.

Issues that are left unproblematic and unarticulated by this problem representation however, include a) the (un)availability of the funding required to provide the ideal quality and quantity of supervision, and b) the resource and healthcare implications of having highly qualified supervisors not directly contributing to healthcare. As though it was aimed at underscoring this latter point, the redistribution and deployment of senior doctors during recent junior doctor strikes resulted in quality delivery of emergency healthcare services, that was even described as "world class" by one news service (Press Association, 2016).

5.3.2 Substandard learners

In *Promoting Excellence* (GMC, 2015c), the GMC also represents the problem as one of 'substandard learners'; those it constructs as not being *responsible* for their own learning, and who, by their choices, actions or inaction, undermine health care and *patient safety*. It asserts: "learners are responsible for their own learning and … must not compromise safety and care of patients by their performance, health or conduct. … and must understand the consequences if they fail to do so" (GMC, 2015c, p. 23). This representation of the problem clearly draws on the discourse of *patient safety*, viewing of students and their activities through a 'patient safety lens' as representing a risk to patients' safety, This, in spite of the fact that the policy clearly declares a move away from a focus on "protecting patients from any risk posed by medical students and doctors in training" (GMC, 2015c, p. 5) to a focus on creating learning

environments that are safe for patients. This representation of the problem also draws on the discourse of *responsibility* and makes the assumption that all individuals possess personal insight; that they have the innate ability to objectively assess all their own activities, distinguish between those that are acceptable and those that are not, and take responsibility for their individual choices. It thus encourages a form of medical education and practice that focuses on navel-gazing and introspection, with an expectation that individuals have insight into all the wider ramifications of their actions.

Promoting Excellence (GMC, 2015c) further constructs the problem as being the result of poor recruitment standards and practices. With the GMC having explicitly renounced an interest in regulating the selection, recruitment and admission of students to medical schools, asserting that "the definition of criteria for the selection of medical students is a matter for individual universities" (GMC, 1993, p. 19), constructing the problem as an issue of the recruitment of substandard learners lays the blame squarely in the laps of organisations. The GMC has carried on this trend of disinterest in recruitment in its subsequent policies, and has explicitly relinquished that responsibility to medical schools and other providers of medical education. For instance, it asserts that a) "student selection is not our direct responsibility" (GMC, 2003, p. 21), b) "medical schools are responsible for … selecting students for admission" (GMC, 2009, p. 10), and "organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent" (GMC, 2015c, p. 21). In fact, a closer reading of its response to frequently asked questions regarding the recruitment and selection of medical students is more explicit in this regard, as the GMC overtly asserts "we don't represent medical schools … It is up to the universities to satisfy themselves that each entrant has the academic attainment and abilities necessary to benefit from the course." (GMC, 2016a).

This assertion is a clear expression of the drive, by the GMC to decentralise and devolve the responsibility for recruitment and selection to medical schools. However, rather than completely repudiate this responsibility, it purports to maintain a modicum of control over recruitment by insisting that medical schools must a) liberalise their criteria for admission and selection, b) facilitate the recruitments of learners from non-traditional backgrounds, c) modify their recruitment criteria to include the identification of affective and non-intellectual attributes, and d) seek to create diverse populations of learners that reflect the diversity of society (GMC, 2015c, 2009, 2003, 1993). The GMC further seeks to control the recruitment

of learners, albeit from a distance, by stipulating the need for medical school admissions criteria to be transparent, non-discriminatory, aimed an promoting equality of opportunity, and focused on selection of only those students with the potential to demonstrate their acquisition of the outcomes laid out in its policy (GMC, 2015c, 2009, 2003, 1993). This desire of the GMC to exert control *at a distance* (Rose & Miller, 1992) is fundamental to the expression of neo-liberal governance without overt repression.

Without explicit controls on recruitment of learners however, the GMC is seemingly not in a position to ensure the suitability of learners for medical education. In addition, by choosing to deregulate this aspect of medical education, and permitting organisations to determine their own selection criteria, the blame for failing learners and doctors is then placed on the individuals or the organisations themselves. Further, by relinquishing the responsibility to organisations, the GMC essentially imposes a free market agenda on recruitment into medical education, freeing up organisations to develop differentiated and marketised recruitment systems. In fact, some organisations have been so freed up in this regard, to the extent that they set additional entry criteria, over and above the traditional requirement for applicants to attain particular grades upon the completion of secondary education (Paton, 2009). This marketisation of recruitment is highly selective and has the direct effect of excluding certain groups, those otherwise unable or unwilling to jump the extra hurdles, from entry into medical education. Historically, the requirements for recruitment into medical education were based on the possession of exclusive non-cognitive characteristics such as socioeconomic status, religion and race (Bonner, 1995). Over time, these criteria were replaced by those based on academic achievement in prescribed pre-medical subjects. These academic criteria merely perpetuated the social divisions in medical education that were already the ramification of segregated secondary education systems, excluding those from state education and privileging the already privileged.

It is notable however, that the GMC's requirement for medical schools to liberalise their recruitment criteria was instigated by a need to respond to public concerns that medical school populations did not mirror the heterogeneity or diverseness of the communities they were meant to serve. Efforts to redress this lack of diversity, and to reverse the exclusion of marginalised groups from medical education and the profession, such as 'widening participation' however, are still unable to effect meaningful change (Mathers, Sitch, Marsh, & Parry, 2011). This may be due to a variety of factors including previous

marginalisation in the pre-university education of those at a stage to apply for entry into medical education, a class mentality associated with the medical profession, and other barriers to social mobility. It is also important to remember that medical education, in keeping with the rest of UK higher education, has also been affected by the introduction of significant tuition fees. This places a significant financial burden on those making the choice to enter into medical education, excludes those unable or unwilling to pay, and raises the expectations placed on organisations by learners. The trouble is that when education becomes a commodity, customers (learners) expect to get their money's worth, and in some cases, undue pressure may be put on organisations and educators to ensure that this is realised.

The GMC's reticence to be seen as being autocratic in regard to the recruitment criteria, and devolving the responsibility over this to medical schools, had further effects. Firstly, as a direct result of the GMC's reluctance to clearly articulate which criteria to use in the selection of learners, the medical schools were able to take advantage of the freedom to distinguish themselves by introducing different recruitment yardsticks. In fact, it has been shown that some of these differential criteria had no predictive value on the fitness of learners to become good doctors (Goldbeck-Wood, 1996). However, the use of non-standard criteria, and particularly the focus on non-cognitive attributes of applicants, effectively made the recruitment and selection processes *appear* less discriminatory on the surface and *attract* more of the non-traditional sorts of applicants.

Paradoxically, while the use of these differential criteria had the effect of attracting more non-traditional applicants, it may in fact favour the recruitment of the more socially advantaged, and perpetuate the exclusion of the underprivileged from medical education. It is, for instance, much easier for an applicant from certain social groups to meet non-cognitive recruitment criteria, such as relevant healthcare work experience and shadowing of hospital doctors and GPs, by drawing on pre-existing networks that are already exclusive to the social groups to which they belong. Further, from the perspective of a potential learner, the multiplicity of different entry criteria means that the question is not whether or not the individual would meet the criteria for entry into medical education in general, but rather if she or she would meet the requirements for admission into a *specific* medical school.

Secondly, the deregulation of recruitment has permitted medical schools to seek to distinguish themselves, compete against each other and utilise whichever criteria met their specific needs, in a free market

economy, and to select those applicants best suited for their distinctive variety of educational provision, as opposed to the selection of all those able to meet the rigorous demands of a medical career. That this has continued to happen unchecked, flies in the face of the explicit assertion by the GMC in its policy that recruitment and selection of learners must be "open, fair and transparent" (GMC, 2015c, p. 22). The effect of the deregulation and marketisation of recruitment and selection of learners has thus been the reduction in opportunities for access to medical education for underprivileged social groups.

Interestingly, the GMC has seemingly abandoned the requirement in its previous policies, that organisations aggressively engineer their recruitment and selection processes to ensure that the diversity of learners reflected that of the general population. This requirement had fostered the proactive provision of access to medical education for some under-represented social groups, and had seemingly contributed to the rectification of the persistent under-representation of women in medical education (Boursicot & Roberts, 2009). However, the diversity of learner populations in medical education still fall short of that of UK society (Steele, 2011). This is not to say that such parity in diversity is actually achievable without proactive measures such as:

a) the imposition of selection quotas on the basis of socio-demographic characteristics that reflect the general population. Such quotas would paradoxically increase the likelihood of the rejection of otherwise qualified applicants on the basis that their quota has run out.

b) the imposition of a lottery-type system for recruitment and selection from a pool of all who meet the minimum criteria. This in itself may not result in equitable representation of socio-demographic diversity but would give every applicant an equal probability of being selected.

c) the imposition of a ranking system for applications to ascribe more weight to pre-determined individual characteristics that could facilitate the fair and equitable recruitment.

Whatever the pragmatic courses of action introduced in order to increase the diversity of learners, their recruitment and selection has to take into account personal characteristics and attributes that may distinguish those most likely to succeed at becoming doctors. Unfortunately, such characteristics and attributes are distributed in an extremely variable pattern in normal society. Further, based on the

explicit assertion by the GMC that its policy is aimed at making proposals for the benefit of society, from the perspective of members of the public, the issue of most importance to them is that organisations recruit the people best placed to become the best doctors, not so much that they are picked to reflect the diversity of society. Thus, since the best interests of society are served by the recruitment of those deemed to meet the criteria to become doctors, there is no social impetus to achieve parity in diversity. Even far more significant is the fact that medical education is a more or less invariable facilitator of social mobility. Learners recruited from under-represented and underprivileged groups into medical education undergo a major change in social status and social class after qualification, to the extent that they can no longer be regarded as being representative of the social groups from which they were recruited. Thus, the aim to ensure parity in diversity between medical education and society by the implementation of policy is illusory at best.

What is apparent from this discussion of the problem of 'substandard learners' is that at the core of the policy is the promotion of neo-liberal ideology. The deregulation and marketisation of the process of recruitment and selection, coupled with the obvious attempt of the policy to effect government at a distance, are key markers of the application of this ideology. The representation of the problem can thus be challenged on two fronts: Firstly, it can be rethought as one of poor recruitment and inadequate preparation for medical education. Rethinking of the problem in this way explicitly links medical education with the structure of society, the social environment that individuals are raised in, and all their preceding formal and informal education. This means that, to be effective in recruiting and selecting the best potential doctors, medical education policy needs to address issues of class structure, formative education and social mobility. This approach makes the assumption that the spectrum of medical education commences at the time of an individual's birth, continues through the formative years and through all levels of formal education before entry to medical school. Such longitudinal preparation would ensure that everyone has an equal opportunity to enter into medical education, and those that do are already guaranteed, in as much as preparatory social processes can, to be good learners and doctors. The main challenges to this approach would be ideological/governance-related and fiscal/resource-linked. Ideological, because the approach draws on Marxist and socialist ideas of equality, and the need for big government managing the entire process and working for the benefit of

individuals. Fiscal, because the approach would require a significant financial and resource outlay to ensure its viability.

Secondly, the problem can be rethought as an issue of ideology, If medical education is viewed as a process that is aimed at meeting the needs of society, then recruitment and selection must be managed in such a way that this aim is realised. Rather than deregulate and marketise the process, it ought to be centralised and managed on an equitable basis, with any prescribed limits on learner numbers being lifted, and medical education being open to all rather than a select few. Individuals would then be given the opportunity to make a decision whether or not to continue in medical education, or perhaps retrain if they are not up to it. The main challenges to this perspective would be that priority has to be given to meeting the workforce needs of the NHS as the main provider of healthcare to UK society, as well as the precarious balance between the cost and value of medical education (Walsh, 2014).

Nevertheless, at the core of the representation of the problem as one of 'incompetent learners' and 'substandard learners' is the presumption that the exclusive purpose of medical education is for the provision of a medical workforce. The GMC asserts for instance, that schools must provide:

> "at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work" (GMC, 2015c, p. 33)

Immediately obvious in this requirement is the construction of the learner as a fledgling worker through a discourse of *work*, and drawing on Nigam's argument, the individual's " subjectivity exists only to the extent that it is fully constituted by the discipline of work (and the market) for, only thus can s/he find a rightful place in the economy" (Nigam, 1998, pp. PE16–PE17). This privileging of work and the construction of the learner as a trainee member of the workforce, is built upon application of the neo-liberal ideology to medical education, which favours the creation of a workforce for the NHS.

5.3.3 Substandard educators

Drawing further on the discourse of *work*, and on the neo-liberal requirement to meet the NHS workforce needs, *Promoting Excellence* (GMC, 2015c) represents the problem as one of 'substandard educators'. It explicitly requires that "educators are selected, inducted, trained and appraised to reflect their education and training responsibilities" (GMC, 2015c, p. 29). In practice, this means that educators, regardless of experience and upon appointment, are expected to either undergo mandatory educational training, or provide documentary evidence of their educational qualifications in order to certify their expertise. This requirement for educational training and certification of educators is not new to UK medical education policy, but was explicitly introduced in *Tomorrow's Doctors* (GMC, 2009), which required that "everyone involved in educating medical students will be appropriately selected, trained, supported and appraised" (GMC, 2009, p. 62). Nevertheless, it is important to note that in its role as a regulator of the medical profession, the GMC only regulates directly those educators that are also registered and licensed doctors. It therefore has no immediate regulatory powers over those educators that are not medically qualified. However, in view of the fact that it exercises its regulatory powers over all the educational activities of organisations, it places the onus on them to assure the quality, achievements and qualifications of all those who have an involvement in teaching learners, thus indirectly regulating all educators whether or not they are medically qualified.

The 'medical educator' identity was insidiously introduced in the *Tomorrow's Doctors* (GMC, 1993) policy, when the GMC asserted its support for organisations appointing staff with a background in education, saying that this facilitated an adequate response to the " educational demands of a modern curriculum" (GMC, 1993, p. 11). By 2003, the GMC was already demanding that what it referred to as "medical educationalists" (GMC, 2003, p. 5), make a contribution to the core medical curriculum. Constructed as scholars of medical pedagogy, the introduction of these medical educationalists to medical education represented a significant move away from the philosophy of teaching by *subject experts*, towards the facilitation of learning by *expert educators*. Building on this representation of the problem, the *Tomorrow's Doctors* (GMC, 2003) policy also precipitated the creation of formal divisions in organisations with its encouragement of the coalescence of "educational expertise within a *medical education unit*"

(GMC, 2003, p. 19, emphasis mine). By 2009 the GMC had gone even further to demand that "*everyone involved in educating medical students* will be appropriately selected, trained, supported and appraised." (GMC, 2009, p. 69, emphasis mine). *Tomorrow's Doctors* (GMC, 2009) also reaffirmed the GMC's support for the creation of medical education units or departments in organisations, asserting the need to involve "people with educational expertise in a medical education unit" (GMC, 2009, p. 71), in the management of teaching, learning and assessment.

By 2015 with the publication of *Promoting Excellence* (GMC, 2015c), the role and identity of what were now referred to generically as 'educators' was firmly entrenched in UK medical education policy. In addition to resulting in the creation of this new identity, the representation of the problem as one of 'substandard educators' further facilitated the development of clear career pathways, and the formation of new academic specialities to revitalise the erstwhile declining *clinical academic* cadre of staff funded by the NHS in conjunction with medical schools (Chan, 2015; Weatherall, 1991). These clinical academic staff only provide healthcare on a part time basis with the rest of their time spent in normal academic tasks (Chan, 2015, p. 65).

The *Promoting Excellence* (GMC, 2015c) policy therefore constructs 'substandard educators' as a) those who meet the selection, training and appraisal criteria but do not participate "positively with training, support and appraisal relating to their role" (GMC, 2015c, p. 29), and/or b) those that are not "accountable for the resources they receive to support education and training" (GMC, 2015c, p. 29). This representation of the problem therefore draws significantly on the discourse of *responsibility*, constructing educators as responsible and accountable for educational training they receive, and ignores any influence of structural forces. It also draws on the neo-liberal fixation with the measurement of performance of workers as a means for domination, control and governance of individuals (Schram, 2015, p. 116).

Historically, all those who taught medical students were either academic experts in the various medical sciences, or clinicians of substantial experience (Schofield, Bradley, Macrae, Nathwani, & Dent, 2010). There was a gradual move in the late 1980's, supported by the GMC, towards the recruitment of experts in higher education by medical schools to help them modernise curricula and establish a solid educational foundation for their academic activities (GMC, 1993, p. 11). There was however, no requirement

during that time that any of those teaching medical students needed to undergo formal training in education, nor was any prescription made about who would be suitable as a medical teacher. In fact, the predominant belief was that having qualified as doctors, the only other prerequisite to guaranteeing that they would be good teachers was their "own experience of education" (MacDougall & Drummond, 2005, p. 1213).

Nevertheless, the emergence of this newer *educator* identity has conflicted with established identities, particularly that of the basic scientist teacher. in fact, as Bleakley et al. argue, "the shift to a scholarship of teaching and learning from that of a jobbing teacher involves a *major shift in identity*" (Bleakley et al., 2011, p. 100, emphasis mine). The basic sciences, those subjects that were traditionally part of the pre-clinical medical course, are increasingly delivered in an integrated fashion, with more modern pedagogic methods in keeping with the recommendations of the GMC. The identity of the basic science teacher has thus been on the decline, coincident with the deterioration of the demarcations between pre-clinical subjects which were their erstwhile responsibility. As a result, basic scientists are increasingly being retrained and re-constructed as researchers or, by taking up formal educational qualifications, being recast as medical educators (Steinberg et al., 2016; Steinert, 2008). While it could be argued that the engagement of educators with scholarship in pedagogical issues would certainly be of benefit to their professional practice, the representation of the problem as one of 'substandard educators' could be disrupted by challenging a) the need to *certify* educators, b) to require educators to pursue formal training, and/or c) to explicitly require that organisations *number* their staff who hold such qualifications (GMC, 2016c). In fact, such enumeration simply derives from the neo-liberal obsession with measurement and marketisation, commodifies educators and marketises their role.

This representation of the problem also creates a conceptual dichotomy of 'good' and 'substandard' educators. It constructs good educators as those with a recognised certification, and substandard ones as those without, with no reference to the actual quality of their work. It thus constructs a two-tier provision of education with certified educators being of a higher order. This representation of the problem has been promoted and disseminated primarily by the publication of GMC policy, and its regulatory regime, which specifically requires organisations to submit comprehensive statistics on the number of clinical educators employed who have formal educational qualifications. Nevertheless, the

Promoting Excellence (GMC, 2015c) policy is silent on the fact that there is no evidence that educators without such certification are necessarily substandard. It is also silent on the financial and resource implications of a formal requirement for additional specialist educational training for those who would like to be educators. Further, particularly in terms of those educators who are also clinicians, the policy is silent on the workforce implications of such a problem representation. Nowhere does the policy articulate the issues of workload management, time out for educational training, or the utility of job plans weighted towards education rather than healthcare. Further, in view of the formulation and publication of *Promoting Excellence* (GMC, 2015c) in the aftermath of the 2008 recession, there is an eerie silence on the impact of the austerities of the UK economy on the NHS and on medical education.

The representation of the problem as one of 'substandard educators' builds on the notion of individual responsibility by urging educational providers to facilitate " learners and educators to raise concerns … openly and safely without fear of adverse consequences" (GMC, 2015c, p. 10), implying in effect that it was/is the responsibility of individual learners and educators to both keep an eye on organisational procedures and practices, and to raise concerns. The effect of this assertion is to construct individuals as elements of the proverbial all-seeing eye of the GMC. In fact, as Sir Donald Irvine, a former president of the GMC asserted, "the GMC has said explicitly that *it expects doctors to report colleagues* whose pattern of practice puts patients at serious risk …And it has demonstrated that it will act against doctors who do not do so" (Irvine, 1997, p. 118, emphasis mine). This inducement to whistleblowing openly promotes a panoptic version of medical education: there are many observers of the activities of individuals and organisations; every individual is potentially an observer, and every activity is potentially under observation. This panopticism has the effect of breaking down the cohesion between team members since anyone could be watching on behalf of the regulator. It has also resulted in learners and doctors being expected to have insight into the wider ramifications of all aspects of their practice, and to expect to be held to account for any failures. This move to panopticism is further reified by an obsession with the documentation, measurement, and "evidence" (GMC, 2015c, pp. 21,44) of every professional activity.

It is important to note here that the GMC itself had long suffered public blame for medical errors amid accusations of the regulator being a cartel for the protection of the medical profession, or a 'doctor's club', and had made and publicised various steps towards its reinvention as an advocate for the public.

In ascribing responsibility to individuals and organisations, rather than itself, it derives the benefit of re-articulating and reaffirming its position as advocate for the public and not the medical profession. In this light therefore, the representation of the problem as one of individual responsibility is, in effect, easily viewed as an attempt to wash its hands of blame where patient safety was found wanting. It has to be borne in mind however, that the GMC's remit only extends over medical education and doctors but does not directly cover all the other healthcare professionals or indeed NHS organisations. As such, this may merely be an expression of the limits of the authority that the GMC wields over medical education.

5.4 Problem organisations

The *Promoting Excellence* (GMC, 2015c) policy also represents the problem as one of 'problem organisations'. In making such a sweeping problem representation, the GMC seeks to encompass in its problematisation, independent organisations that have very little in common beyond medical education, namely: "postgraduate deaneries and LETBs … medical schools (and the universities of which they are a part) … LEPs … Colleges, faculties and specialty associations" (GMC, 2015c, p. 17). It constructs such 'problem organisations', through a 'patient safety lens', as those which do not a) demonstrate a culture that facilitates whistleblowing in regard to patient safety, b) have systems in place to investigate patient safety concerns and learn from them, c) provide adequate supervision for learners to prevent patient endangerment, d) provide adequate learning resources and facilities, and e) distribute clinical workload effectively (GMC, 2015c, pp. 10–15). As such, it constructs this overarching representation of the problem as one that subsumes the foundational problem representations of 'poor organisational culture', 'substandard workforce distribution' and 'bad governance' in these organisations. I discuss these representations of the problem in the following subsections.

5.4.1 Poor organisational culture

In *Promoting Excellence* (GMC, 2015c), the GMC demand that organisations should ensure that medical education is "a valued part of the organisational culture" (GMC, 2015c, p. 5). In making this assertion,

GMC utilises the taken for granted discursive formation (Foucault, 1972) of 'organisational culture' to denote the ideas, customs and social norms of organisations as expressed in the values that they hold. The discursive formation of 'organisational culture' is the normalisation and rationalisation of the notions of 'organisation', signifying a social group existing to perform a particular purpose; and of 'culture', signifying the ideas, norms and behaviour of a social group. The use of 'organisational culture' in this policy creates peculiar subjectivities and subject positions, for example the position of the 'members of the organisation'. These members are constructed in various ways as subordinate to the organisational culture, and thus subservient to the organisational values. *Promoting Excellence* (GMC, 2015c) also utilises 'organisational culture' insidiously to instigate the alignment of NHS organisations and their members with the educational values expressed in the policy.

Clearly, the development and promotion of defined organisational values is often utilised as a mechanism of effecting organisational change (Padaki, 2000). However, merely holding to a determined list of organisational values does not mean that the members of an organisation actually perform according to those values, or that the values themselves significantly change the ideas or social norms of the individuals within organisations. The representation of the problem thus makes the assumption that organisations hold shared (as opposed to merely 'declared') values, and that these values are shared across the spectrum of their members in a fashion that can be guaranteed. In fact, Kleijnen, Dolmans, Muijtjens, Willems, and Van Hout (2009) argue that there is often a conflict between the values overtly expressed by an organisation, and those that are preferred by its members. This conflict really means that organisational values are seldom enacted as articulated, and members may even hold and express values contrary to those of the organisation. Nevertheless, the fact that the values being imposed by the GMC in its policy are being delivered in a top-down approach, has the intended effect of silencing contrary ideas and values, and restricts the ability of those values that are truly shared between members to gain prominence and acceptance at the organisational level.

This predominantly neo-liberal representation of the problem depends on the assumption that these organisations are, or should be, providers of education and training. However, as I have argued above, it fails to recognise the difficulties posed by the fact that for the vast majority of these organisations, their mainstay is healthcare services, with education and training being a distant secondary (or even

tertiary) concern. In fact, the vast majority of the funding and resourcing of these organisations is aimed at providing healthcare, with much less going towards education and training. In addition, the minority of NHS organisations which have a significant educational role, strong links to medical schools, and significant research activity are specially designated as 'teaching hospitals'. While it is certainly true that education occurs in every setting in which medical practice is ongoing regardless of the designation, this differential construction of NHS organisations creates differences in opportunities (and perspectives of the availability of such opportunities) for education and training for those learners that end up in them.

The issue here is that the GMC only possesses statutory powers over doctors, their education and training. The educational and NHS organisations providing the learning environment, do not directly fall under the regulation of the GMC (with the exception of medical schools) and thus operate according to criteria that cannot be directly governed by GMC policy. These organisations are obliged to provide adequate healthcare in the first instance, and where decisions have to be made between healthcare and educational provision the priority must be given to healthcare. This makes educational provision a second class citizen in the local ecosystem regardless of the imposition of organisational values by the GMC. In fact the NHS, whose resources and infrastructure are primarily utilised in the provision of the learning environment, is a major employer in the UK employing over 1.6 million people. The NHS is funded primarily from taxation making it inherently accountable to the government and the tax payer. Its employees, infrastructure and resources are focused on the provision of healthcare, free at the point of need. As such it would strive to be viewed as prioritising its primary role, that of providing healthcare, as opposed to focusing on medical education and training. The recent era of austerity has further limited the ability of all those receiving government funding, including the NHS, to prioritise activities not directly related to the functions for which funding is received. As such, this policy appears blind to the effects this austerity would have on the ability of organisations to prioritise educational activities and provide the kind of learning environment and culture it calls for.

This representation of the problem is mainly produced and disseminated in the various publications of the GMC itself. More recently however, the news media coverage of government involvement in junior doctors contracts and weekend working (BBC, 2016) have turned the spotlight on education and training in the NHS, and provided an avenue of challenge of this representation; that, medical education is not

the primary responsibility of organisations themselves, but that of the state in the sense that it is the state that is ultimately driving the provision of both medical education and healthcare.

Representing the problem as one of organisational culture and values in relation to medical education is also dependent on a functionalist world view, in which the singular purpose of education is to guarantee the acquisition of core knowledge, values and skills that ensure that a particular individual is able to perform a prescribed social function. It is a view of medical education that facilitates the imposition of certain forms of social control over the individual learner or educator in order to ensure the creation of a workforce suitable for the form of health care constructed by the policy. The problem could thus be rethought, a) in view of the focus in the policy on organisational values, as an issue of control and the exercise of power by the authoritative allocation of values; the values of the GMC being re-articulated and represented as organisational values, and b) in view of the aim of creation of a suitable workforce, as an issue of the industrialisation of medical education.

5.4.2 Substandard workforce distribution

Drawing on, and extrapolating the aforementioned representations, 'poor organisational culture', 'patient endangerment' and 'individual responsibility', *Promoting Excellence* (GMC, 2015c) further represents the problem as an issue of deficiencies in workforce distribution. It makes the assertion that organisations must guarantee the availability of sufficient numbers of qualified staff to ensure "appropriate clinical supervision, working patterns and workload, *and* for patients to receive care that is safe and of a good standard, while creating the required learning opportunities" (GMC, 2015c, p. 11). The policy further asserts the need for organisations to ensure that learners have adequate and appropriate supervision at all times, demanding that organisations undertake to ensure that "learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed" (GMC, 2015c, p. 11).

This representation of the problem makes the assumption that the distribution of suitably qualified clinical staff in these organisations, and their funding and resourcing, is simultaneously propitious for

the facilitation of *both* education/learning and the provision of healthcare. It further derives from neo-liberal axioms in which potential workers, in this case the learners, ought to be nurtured and prepared for a contribution to the workplace, and once in place, should be distributed according to the needs of the organisation or establishment for which they work. Nevertheless, the policy is silent on the financial implications of the provision of a workforce sufficient to provide the required level of clinical supervision, and to furnish the desired quality of health care. Nothing is articulated in the policy as to *who* will fund the required clinical supervisors, and *how* to maintain adequate numbers as some staff retire, move on, or cease to work for these organisations. A significant proportion of these clinical supervisors are actually trained and attain their qualifications whilst working for these organisations. Consequently, maintaining adequate numbers requires a programme of rolling investment in staff – implying a significant financial outlay. Also, as I have articulated previously, this brings into question the management of the balance of funding between education and healthcare, even though the policy is silent on this.

This representation of the problem is maintained and disseminated by various means, including parliamentary debates, the public pronouncements of ministers, and the news media publication of emotive issues, such as coverage issues related to the provision of healthcare during the weekends and particularly how this relates to the contracts of junior doctors (BBC, 2016; Marsh, 2016). However, the representation of the problem can be rethought as an issue of state dominance and hegemony, in the sense that the supply of suitably qualified doctors is limited by the state, which tightly controls the number of specialist trainee and consultant posts (Department of Health, 2016; CFWI, 2011). These numbers are presumably the result of limitations in the availability of state funding for medical education and training on the one hand, and the express needs of the NHS workforce on the other. Drawing on neo-liberal ideas, it could be argued that such state control over the number of training posts, and the explicit linking of these to the requirements of the NHS, helps to ensure an adequate workforce. However, such central control and restrictions also limit the flexibility of organisations to ensure that they have an adequate supply of qualified staff, without reliance on the state, and to replace those staff leaving the service, since such supply is dependent on the numbers of those in medical education at the right level.

5.4.3 Bad governance

The *Promoting Excellence* (GMC, 2015c) policy asserts that "it is in the public and patients' interests that there is effective, robust, transparent and fair *oversight* of education and training" (GMC, 2015c, p. 16, emphasis mine). By making this assertion, the policy represents the problem as one of 'bad governance'. It draws on the assumption that educational organisations have a duty to ensure accountability to society, and draws significantly on the discourses of *patient safety* and *responsibility*, implying that when medical education and training occurs in a fashion that is not open to public scrutiny, it puts patients at risk of harm.

This representation of the problem also draws on the history of UK medical education, as I have described in section 2.2, in which the GMC was viewed as an insular cartel established for the protection of the medical profession. The public response to the coverage in the news media of medical scandals brought this insularity into question, and the resulting restructuring of the GMC, and its explicit self-identification as an advocate for the public, has driven its trajectory towards transparency and social accountability. Nevertheless, these moves do not help to clarify to what extent medical schools, in contrast to NHS organisations, are public institutions subject to scrutiny by society, over and above that expected of the universities of which they are an integral part. In fact, representing the problem as such merely serves to tar all organisations with the same brush, and obfuscate any distinctions between them. Thus, the policy is silent on the fundamental distinction between organisations, and silences any attempt to challenge or manifest distinctions.

The unforeseen effects of this problem representation and the resulting public scrutiny are that medical education and practice are propagated as entities for the elite. The argument for this is that if medical education and practice are subject to such public scrutiny, they also deserve their social placement as opportunities for the elite. The conceptual elevation of medical education over and above other forms of higher education provision, propagates the exclusion of certain socio-economic groups and social classes from entry into medical education. As a result, the populations of learners and doctors are prevented from being reflective of the communities they are located in.

This representation of the problem is disseminated by the public vilification in the news media of medical errors and scandals, and by public ministerial and GMC pronouncements of standards expected in medical practice. However, it can be disrupted by questioning the role of public scrutiny in the provision of medical education. Asking for instance, a) to what extent is a virtually decentralised educational organisation subject to public scrutiny, and b) what is the place of centralised scrutiny and control in a largely marketised and liberalised educational system?

The problem of 'bad governance' is further represented as an issue of centralised, monolithic and inflexible mechanisms of regulation and control of medical education. In this view, educational organisations are not perceived as adequately responsive to the establishment of regulatory control by the GMC. This perspective of the problem is derived from the historical relationship of educational organisations and the GMC and its predecessors, which was marked by the resistance of powerful medical corporations to GMC regulation, and the resulting stratification and variability of medical education (Irvine, 2006). This representation of the problem is primarily disseminated by the GMC, particularly in its publication of medical school inspection reports, which make specific mention of the (in)sufficiency of their governance practices and procedures..

Representing the problem as an issue of 'bad governance' is apparently blind to the relationship between medical education providers and other entities. Importantly, organisations that provide medical education are also accountable to other governmental and non-governmental bodies that may not be regulated by the GMC. For instance, UK medical schools have an intricate relationship with both the universities of which they are an integral part, and the NHS. While medical schools are regulated by the GMC, universities and the NHS fall under the oversight and jurisdiction of other organs of the state that are independent of the GMC. The interests of these other organs may in some cases supersede those of the GMC. It could be argued in this light therefore, that this is the manifestation of issues regarding the structure and organisation of medical education in the UK, and that the way forward is to sanction the detachment of medical schools from universities to create standalone medical schools with the power and standing of universities. Such segregation of the schools from their parent universities would serve the purpose of bringing all their activities under the jurisdiction of the GMC, but on the other hand, it would serve to fracture the cohesion between higher education provision – exacerbating the intellectual divisions

between medical and other higher education. This representation can thus be disrupted by querying whether or not this is a question of the fine balance between centralisation and the marketisation of medical education.

5.5 Discontinued problem representations

Studying the *Promoting Excellence* (GMC, 2015c) in conjunction with its predecessors grants a useful insight into the genealogy of the representation of policy problems. Importantly, it also permits a view of some representations in previous policies that have since been discarded and/ or replaced. In this section, I briefly consider the more prominent of these erstwhile representations of the problems in UK medical education policy.

5.5.1 Population composition

Missing from the *Promoting Excellence* (GMC, 2015c) policy is the representation of the problem as an issue of the composition of the population. In its previous policies, the GMC had asserted the need for medical education to recognise that the UK had "an ageing *population* of multi-racial *composition*" (GMC, 1993, p. 4, emphasis mine), and as a result, to prioritise the "care of the elderly and the chronic sick, understanding of the scope of rehabilitation, pain relief and care of the dying" (GMC, 1993, p. 4).

Medical education was thus constructed in this policy as being fundamentally broken in regard to its recognition of population change and needing to be fixed; by this and other related policies. Medical education was further viewed as being biased towards the provision of only specific aspects of healthcare. The policy sought to re-construct medical education as needing to deal with "all aspects of human disorder" (GMC, 1993, p. 4). This was an extrapolation of the GMC's drive towards a change in the focus of medical education away from hospital based services towards primary care. Proposals for changes in medical education were thus aimed at training staff to deal with the healthcare implications of the changing population, contributing to the needs of society, and thus bringing the overall financial forces on the healthcare system under some control.

Further, implicit in this representation of the problem was the assumption that medical education was viewed as a social issue; not meant to be undertaken purely for an individual's own interests or career goals, but, drawing from a socialist ideology, for the primary and perhaps sole role of making a contribution to society. In its articulation of the need for medical education to make changes in response to its proposals, the GMC asserted that there was a need to recognise that there was a greater "understanding of disease and disability", "expectations have risen", "patients are concerned" and "the relationship between doctor and patient has changed" (GMC, 1993, p. 4). The policy went on to assert that their proposals were warranted by the rapid changes and innovations occurring in science and technology that had practical implications for medical education and practice, as well as the changing expectations of society which had a greater "understanding of disease and disability" (GMC, 1993, p. 4).

No evidence for these assertions was proffered, and these statements were made as though they were not the subject of any controversy. As such, while this statement purports to report the altered relationship between the medical profession and society as a driver for this policy, it might be said that its aim was to paint the picture of the profession as not having responded to the contemporary societal change, and thus desperately in need of change. It has always been the case that the doctor-patient relationship has been in a constant state of evolution throughout the existence of the medical profession, particularly more recently as medical knowledge has become more widely available and accessible to the public (Kaba & Sooriakumaran, 2007). The problem is thus constructed as being compounded by the elitism in medical education, with the profession portrayed as being aloof, resistant to change, and not being representative of, or accountable to society.

Nevertheless, representing the problem as an issue of the composition of the population inevitably constructed it as a matter of social welfare; a predicament that therefore had significant fiscal, logistic and infrastructural implications for the state, and conflicted with the inclination of the state towards decentralisation and marketisation of medical education. It is therefore unsurprising that this problem representation was expunged from subsequent UK medical education policy. However, as I have discussed above, representing the problem as an issue of social welfare offers an avenue for challenging and disrupting the other prominent representations of the problem because it foregrounds the responsibility of the state to ensure the welfare of all its citizens.

5.5.2 Information overload

Also discontinued in the *Promoting Excellence* (GMC, 2015c) policy is the representation of the problem as one of 'information overload'. In its 1993 policy, the GMC asserted the need for medical education to reduce the "burden of information" imposed on medical students, and to help them acquire the "ability to work independently" (GMC, 1993, p. 5). It reiterated this in its 2003 policy, urging medical schools to reduce the burden of information "to the essential minimum" (GMC, 2003, p. 5). The GMC was explicit in their guidance to medical schools to reduce the expectations of knowledge in students, and to reduce the amount of timetabled contact time. The policy framed this as a response to age-old complaints concerning the academic burden imposed upon students.

However, information overload has never been an essential attribute of medical curricula, and most curricula are designed to ensure that their outcomes are indeed achievable by students (Monkhouse & Farrell, 1999, p. 132). In addition, medical schools would have been at fault to prevent students acquiring as much knowledge and skill as they themselves chose to acquire. The other issue at hand, is the fact that medical education is not complete at graduation from medical school, and the burden of information imposed upon a doctor is perhaps far more after they leave medical school than before.

In addition, in quoting historic GMC recommendations on the overload of factual information, *Tomorrow's Doctors* (GMC, 1993) does not take into account the increase in duration of education and training (and thus the concomitant increase in information that specialists are required to learn) since the publication of those recommendations. The introduction of postgraduate specialist training, and the increase in duration for this part of training, both reflected the need for doctors to acquire increasing amounts of information, and for the duration of training to increase concomitantly. In fact, the GMC went on to argue this very point, asserting that the introduction of a pre-registration year following completion of undergraduate training was necessary in order to ensure that doctors had the required knowledge and skill in order to practice safely without supervision. In addition, the GMC quoted directly from the *Todd Report* (Todd & Royal Commission on Medical Education 1965-68, 1968) affirming the fact that undergraduate medical training was in fact not sufficient in itself to prepare a doctor for independent

practice. In this sense therefore, the GMC conflated historical and contemporary issues to craft a warrant, and justify its representation of the problem.

In practice however, representing the problem as an issue of 'information overload' resulted in the significant truncation of the time in the medical curriculum made available for students to acquire critical knowledge and skills, to receive teaching in individual subjects, and for the delivery of overall curriculum outcomes. The policy even contradicted its own position on reducing the amounts of factual information required by medical students by asserting that "it was regarded as essential in the public interest that the doctor graduating from medical school should have a comprehensive knowledge of medicine sufficient to meet all contingencies" (GMC, 1993, p. 5). The amount of knowledge, skill or competencies required to meet all contingencies is not fixed, and in fact increases as the number of contingencies increases. Thus, by implication, the amount of knowledge required to meet the GMC's own recommendations would have been subject to possible increases. This concern with the burden of information was conspicuously absent from its subsequent policies. The problem, as it were, had either been dealt with, or it had been relegated in importance.

What the expunction of these erstwhile representations of the problem from UK medical education policy illustrates, is the provisional nature of policy problems; that they are dependent on their promotion and dissemination within the policy, and that they can be selectively expunged when they no longer serve the purposes of the policy. However, they may also serve as avenues for the challenge and disruption of newer representations of the problem, as I argue in section 5.5.1 above.

6 Conclusions and Recommendations

In this chapter, as I wrap this thesis up, I appraise the research direction I took and the methodology and methods I chose, the challenges that these have raised, and summarise the major findings of my analytical work in the previous chapter. I further reflect on the journey it has taken to get to the culmination of this work, and make some concluding remarks in regard to the implications of my finding on my own practice, and on the professional activities of other medical educators.

6.1 Approach to the study

At the design stage of this study, I faced the uncertainty of setting limits on what was desirable and feasible to pursue. Having identified the lack of a robust critical analysis of UK medical education policy in the literature, I faced the crucial decision of whether or not a documentary analysis on its own would meet the rigorous demands of a doctoral thesis; and whether, in addition to the documentary analysis, I would also need to conduct empirical field studies including key informant interviews to bolster and help triangulate my findings. Utilising a combination of documentary analysis and interview data was my first consideration. However, it was clearly fraught with both pragmatic and intellectual complexities. On one hand, interviews with the policy authors at the GMC would help to elucidate the intentions of otherwise unclear aspects of the policy and provide a first-person perspective of the negotiations and compromises inherent in its formulation. On the other hand, it would be dependent on the ability of interviewees to recall intricate details of interactions and discussions that in some cases may have taken place a couple of decades or more in the past. In addition, it would have placed undue focus on the early part of the policy

cycle – a part that was not of particular relevance to most medical educators to whom interpretation and implementation were important. Further, thinking pragmatically about the work that has gone into the production of this thesis, interviews would have necessitated a significant amount of travel and fieldwork, which may not have significantly added to the findings.

On the other hand, a deep documentary analysis had the benefit of negating the need for significant effort in data collection and study. It also had the advantage of dealing with an aspect of the policy process with which most fellow educators were already familiar, and would thus have the potential benefit of producing findings that were within their intellectual and professional reach. Further, there appeared to be significant benefit to be gained by the deep perusal of already published policy material to elucidate the multiplicity of meanings transmitted in the documents, and from a focus on the representation of problems within them.

A superficial reading of the already-published policy documents and related material publicly available on the GMC website revealed that the amount of possible data for analysis was immense. It was clear then that there was sufficient breadth and depth of study material to warrant a straight forward documentary analysis of the significantly sized policy documents and still have the ability to triangulate and reinforce my findings with the evidence from related documents. A focus on published policy documents meant I needed a mechanism by which I would be able to critically analyse their content in a coherent and robust manner. My search of the literature led me to a significant body of work on problematisation in policy analysis, and specifically to Bacchi's work on the WPR approach to policy (Bacchi, 2009).

A deeper perusal of the policy documents themselves revealed that significant steps had been taken to sanitise them of the clear articulation of policy proposals that may seem partisan, 'biased' or subjective. The bulk of the policies were, in fact, written as curriculum documents rather than standard policy documents. However, it was possible to extract the policy proposals from these documents (most of these proposals were merely implicit in the solutions posited rather than articulated as explicit proposals), from these documents, most of which were articulated as mandatory requirements placed upon those governed by the policy, and identified by the ubiquitous use of the modal verb 'must'. I therefore, applied the WPR approach (Bacchi, 2009) to the analysis of these documents, paying attention

to the recurrent nature of some of the representations of the problem(s) – the recurrence highlighting those representations that were dominant, and the discourses that were privileged in the policy.

6.2 Thesis Outcomes

In developing this thesis, I sought to make sense of the UK medical education policy formulated by the GMC, in view of its central role in the regulation of medical education practice, and on what I had observed of its influence on the changing identities and roles of teachers over the years that I have been involved in medical education. I therefore asked the following overarching research question:

"**What is the problem represented to be in UK medical education policy?**"

I sought to answer this question by utilising an interpretive, post-structuralist methodology applying Bacchi's (2009) WPR method to UK medical education policy – specifically to the GMC's current policy *Promoting Excellence* (GMC, 2015c), and diachronically to the previous *Tomorrow's Doctors* (GMC, 2009, 2003, 1993) policies.

Therefore, in my analysis of UK medical education policy, and specifically in answer to the research question above, I have found that:

- UK medical education policy is multifaceted, in the sense that it attempts to tackle multiple 'problems' covering the entire spectrum of medical education. The representations of the 'problem' that are ascendant in the policy *Promoting Excellence* (GMC, 2015c), and that had emerged and became entrenched in *Tomorrow's Doctors* (GMC, 2009, 2003, 1993), are those of *patient endangerment* and *individual responsibility*. These two representations undergird and permeate virtually all the other 'problem' representations in the policy, namely: a) *problem education* – comprising i) *problem learning environments*, and ii) *problem curricula*; b) *problem individuals* – comprising the problems of i) *incompetent learners*, ii) *substandard learners*,and iii) *substandard educators*, and; c) *problem organisations* – represented as problems of i) *poor organisational culture*, ii) *substandard workforce distribution*, and iii) *bad governance*.

- From the perspective of the GMC policies by which it is governed, UK medical education is predominantly viewed through the triple discursive lenses of *risk*, *patient safety* and *responsibility*. The identities, subjectivities, roles, relationships and activities of individuals, groups and organisations in medical education are therefore constructed in light of this triple view. These discourses are privileged throughout the policies, and form the main discursive glue that links virtually all the GMC's proposals, both within and between individual policies.

- UK medical education policy constructs medical education, through the lenses of *risk* and *patient safety*, as potentially detrimental to the well-being of patients receiving health care, and increasing the likelihood of their endangerment due to shortcomings in medical curricula, and the inadequacy of learning environments in which this care is delivered.

- UK medical education policy responsibilises the individual learner and educator, constructing them as rational agents who, given the freedom to choose, are capable of making the 'right' decisions in all circumstances. These individuals are further constructed as having the ability to act both insightfully and judiciously in their practice, independently of structural influences, and are thus accountable for the choices that they make in relation to healthcare and patient safety, and responsible for any shortcomings and inadequacies in this regard.

- UK medical education policy purports to act for the good of society, and on behalf of patients, but incongruously constructs organisations through a neo-liberal lens as ideally placed to deliver efficiencies in the provision of medical education and health care, in a decentralised and deregulated free market economy.

Overall, there is substantiation in UK medical education policy of a sustained trend towards surveillance, measurement, 'objective' comparison, panoptic practice, governing at a distance, decentralisation and marketisation. This is reflective of the promotion of neo-liberal ideologies by the various UK governments under whose jurisdiction these policies were formulated and published.

6.3 Contribution

In this section I lay out the main theoretical, methodological and substantive contributions of this thesis to the field of medical education particularly, but also to the wider fields of education, sociology and policy studies.

6.3.1 Theoretical and Methodological

The first theoretical contribution that this thesis makes is that it clarifies the perspective that policy, and specifically the solutions or remedies within it, are not necessarily made in response to pre-existing social problems but rather to such 'problems' as are constructed discursively in the policy. Problematising the problematisations is demonstrated as a useful means for the analysis, critique and questioning of policy, and as a means for unearthing the assumptions and presumptions that underpin the development of these policy 'problems'.

Secondly, this thesis helps to demonstrate the interrelatedness and interdependence of policy to prevailing ideology, discourse and other contextual and contemporary phenomena. This challenges the positivist perspective of policy as a value-neutral phenomenon created in axiomatic isolation, and shows how it is in fact a derivative of a multiplicity of discursive phenomena.

Closely related to, and indeed derived from the theoretical, is the methodological contribution that this thesis makes, which is that it demonstrates viability of the post-structural approach, and particularly the use of Bacchi's (2009) WPR method, as an alternative method of interrogating policy in the field of medical education. It contributes another methodological tool to the pool of those *not based* on positivism or post-positivism in medical education research (Bunniss & Kelly, 2010). It further helps to demonstrate that the objectivist approach to the sanitisation of policy of statements and phrases that might reveal 'bias' and/or value-ladenness, sanitisation which is characteristic of medical education policy, is not necessarily an impediment to the extraction of useful interpretive data.

6.3.2 Substantive

The empirical or substantive contribution that this thesis makes is that it reveals how the 'problems' of medical education in the UK have been conceived, how particular ways of understanding the problems have risen to dominance, and are being privileged in policy. It further elucidates how particular ways of articulating policy solutions not only constrain the ways in which the problems may be understood but also limit the options of those interpreting and implementing them. Specifically, this thesis elucidates the undercurrent of the discourses of *risk*, *patient safety* and *individual responsibility* that undergird the representation of 'problems', and the solutions posited in response to these 'problems' in UK medical education policy. These discourses interact to produce particular subjectivities in the learners, doctors, educators and organisations that are governed by means of this policy. The pre-eminence of these aforementioned discourses also limits the possibility of alternative conduct, and restricts the emergence and expression of alternative discourses.

6.4 Limitations of the study

While the amount of data available for study from the GMC website was immense, this study was constrained by the more pragmatic aims of meeting the narrow requirements and deadlines for the production of a robust doctoral thesis with a limited word count. These pragmatic aims meant I had to limit myself to data that was directly pertinent to policy analysis, and resist the intellectual curiosity that urged me to delve both deeper and wider. The continual public availability of this data is however useful as a resource for further research outside the confines of a doctoral study.

Further, this study was limited by the paucity of literature in the field of medical education policy analysis and particularly in the areas of the use of interpretive methods. As such I relied on more generic literature and theories from the related fields of sociology, public policy and critical policy studies, with the presumption that there were no significant differences between medical education policy and other public policies. Beneficially however, this limitation also served to identify an intellectual niche in which

to locate this work, and into which to aim to contribute both by the work in this thesis, and in future work in medical education.

These limitations however, did not significantly affect the study itself but merely restricted its overall scope.

6.5 Future research directions

This thesis has addressed, and raises a number of lines of inquiry which would merit intellectual scrutiny and thus create opportunities for further research. The arena of medical education policy analysis both in the UK and globally is relatively unexplored at the macro, meso and micro levels (Bleakley et al., 2011; Musick, 1998). With the looming exit of the UK from the European Union (BREXIT), the ensuing refashioning of the UK's relationships with the European Union and globally, and in view of the impending withdrawal from the direct regulatory influence of European Union Legislation, the time is ripe for an exploration of the effects of these changing phenomena on UK medical education policy. In fact, the changing political climate within the UK itself, and particularly in the devolved nations, brings to critical policy studies a rather unexpected windfall of targets of analysis.

Further, having successfully utilised Bacchi's WPR framework on the breadth of UK medical education policy, and in particular the revelation of the major problematisations in these policies, has opened up several directions for future research including but not limited to the following:

- The application of the WPR framework to other policies directly impacting the medical education arena, such as Government policies on Patient Safety (https://www.gov.uk/government/policies/patient-safety), and on Research and innovation in health and social care (https://www.gov.uk/government/policies/research-and-innovation-in-health-and-social-care).
- Interpretive studies of the UK medical education policy process including interviews of policy makers at the GMC and in Government in order to build on the findings of this thesis. This is

particularly pertinent in view of the development of a national medical licensing assessment, a momentous occurrence in UK medical education that is currently at the public consultation phase.

- Finally, critical discourse analytical studies of medical education focusing on discourses such as risk, patient safety and responsibility that have been illuminated by the analytical work in this thesis. Such studies would build on the emergent application of discourse studies to medical education (Park, 2012; Roberts & Sarangi, 2005; Roberts, Wass, Jones, Sarangi, & Gillett, 2003) as well as the large body of work on discourse in medical encounters (Potter & McKinlay, 2005; Roberts & Sarangi, 2005; Ainsworth-Vaughn, 2001; Ainsworth-Vaughn, 1995).

6.6 Reflexive Account

Having been exposed to the possibility and desirability of policy studies in medical education, my intention at the start of this work was to elucidate the policy process for medical education in the UK. I quickly realised what a massive undertaking this was, given the limited time I had in the midst of a full time academic job, raising a young family and ensuring I maintained the goodwill of my employer in my pursuit of doctoral studies. On reflection, while this was a good time in my intellectual maturity to pursue doctoral studies, it has certainly placed significant strain on my ability to juggle all these disparate, and often conflicting aspects of my life.

It has however been a journey of illumination. Coming from a strongly positivist-objectivist-realist perspective, undertaking the doctoral studies challenged a lot of my own preconceptions regarding what it meant to carry out research, and how to critique and interpret my own and others' findings. It opened my eyes to the possibility of rigour in interpretive research without the positivistic comforts of reliability, statistical significance and reproducibility which had been the mainstay of my erstwhile academic life. Changing research paradigms was perhaps the most challenging aspect of this journey, as well as the fact that the longer things took to be completed, the more my perspective of the phenomena I studied seemed to shift. Even more significant was the fact that, as a result of delays in completing this thesis two years ago, a brand new policy from the GMC was released and came into effect in January 2016.

Obviously, in order to maintain the relevance and applicability of my research I needed to incorporate this, with a significant increase in the intellectual burden it brought with it.

On the upside, I feel that this journey has been of immense intellectual benefit to me personally and professionally, and has opened up the possibility of the further development of my career in the direction of the uncertain world of interpretive research and policy studies.

6.7 Concluding remarks

Overall, the analysis I have undertaken has demonstrated that UK medical education is problematised in policy into five major themes, namely: problem education, problem individuals, and problem organisations which are linked by a common problematic thread of patient endangerment and individual responsibility. All the proposals contained within GMC medical education policy seek to solve problems in these categories and draw significantly on the neo-liberal discourses of *risk*, *patient safety* and *responsibility*. A closer reading of the latest policy in conjunction with its predecessors further shows evidence of the emergence, development, evolution and perpetuation of these discourse and problem themes diachronically through each iteration of UK medical education policy.

What these problem themes uncover is an undercurrent of neo-liberal thought typified by the decentralisation, deregulation and marketisation of medical education and healthcare, with the concomitant application of government-at-a-distance, and the establishment of panoptic forms of regulation. The privileging of the discourses of *risk*, *patient safety* and *responsibility* throughout the policies of the GMC, and within the practice of medical education are a substantiation of the premise that neo-liberal ideas have become entrenched in the practice of medicine and medical education. While on the surface and in the public, medical education, medicine and healthcare issues are articulated with rhetoric to the effect that these 'public affairs' are being provided and managed for the 'good of society', the subliminal message is one that champions the neo-liberal tenets of individual responsibility, commodification, monetarism, decentralisation and privatisation, deregulation and cuts to the provision of social care.

Arguably, we are living in a post-Keynesian era of neo-liberalism however, it is of significance that this core neo-liberal ideology is prevalent in all the GMC policies regardless of the overt political leanings of the government under which each policy was formulated and enacted. In addition, the NHS as the mainstay for healthcare and medical education provision is increasingly decentralised and marketised under the guise of making it more autonomous, flexible and modern. Thus, there has been a significant move away from the socialist-leaning foundation of the NHS (Powell, 1997), whilst still attempting to maintain its core features, namely a taxation-derived funding-redistribution model, and on-demand and comprehensive access to health care services on the basis of need (Appleby & Rosete, 2003). As Powell (1997) argues however, there's little to show for the NHS's claim to socialist ends. Nevertheless, how the NHS (and by inference, medical education that is dependent on, and contributory to it) is run and the quality of service it provides, are the issues of significant importance to UK society (Ipsos MORI, 2015), even though there are fluctuations in discontent and mistrust of the Government's role in its management (Appleby, Robertson, & Taylor, 2016).

Therefore, mounting an effective resistance, and contributing constructively to the formulation of medical education policy for the benefit of UK society as a whole, requires an elucidation of the ideas of the neo-liberal agenda and the illumination of how these have spread throughout medical education and practice (Brown & Baker, 2012). However, resisting the entirety of neo-liberalism in medicine has the potential to fail, because of its virtual entrenchment in every aspect of life in the UK (Hill, 2014). However, it is possible to mount an effective challenge by identifying, illuminating, estranging and challenging the encroachment of those taken for granted discourses and discursive formations that have taken on the semblance of 'truths' in medicine and medical education; 'truths' such as risk, patient safety and responsibility, and casting light on their insidious invasiveness.

In light of these findings, it remains for medical education and educators as a whole to make the crucial choice to either ride the tide of neo-liberalism, or challenge its implementation in this last stronghold of services for the public good. Continuing to play to the neo-liberal tune of distinctiveness and competition, by seeking to create distinctive brands of medical education, applying reductionist and instrumentalist approaches to educational practice, measuring, comparing and relying on 'independent' measures of

'performance', 'quality' and success, merely serve to propagate the neo-liberal agenda, further distancing medical education and medicine from its social contract.

I contend therefore, that it is necessary for medical educators to hold the state and the regulator to account, by illuminating, critiqueing and resisting the ubiquitousness of neo-liberal ideology, and the privileging and propagation of neo-liberal discourses throughout medicine and medical education. To begin to successfully challenge this encroachment, individuals and organisations ought to seek and utilise common criteria for the recruitment and selection of learners; have universally agreed curricula and assessments, and common criteria for qualification - including perhaps a move towards common qualifying assessments. It would also require, particularly in aspects of recruitment and selection, affirmative action to ensure inclusivity and encourage participation from all social groups. Efforts beyond the cosmetic widening participation activities already promoted in UK higher education would need to be undertaken, with the explicit engagement by organisations with primary and secondary education to provide guidance, effective mentoring and the nurturing of all those with an interest in medical education to ensure equity of opportunity. Further, active involvement by educational organisations in community activities, and the promotion of community participation in the governance and educational activities of these organisations, would promote an awareness in the community of the inner workings of medical education, and thus perhaps foster interest in healthcare careers in those otherwise marginalised by their position in society.

References

Abedin, M. (2013). Telling the whole story: Using multiple lenses for policy analysis. In *LSE Research Festival 2013: Exploring Research Stories Through Visual Images, 01 March 2013*. London, UK: London School of Economics and Political Science. Retrieved March 17, 2017, from http://eprints.lse.ac.uk/49227/1/Abedin_Telling_story_policy_2013.pdf

Addison, C. (1950). *Hansard, HL Deb vol 166 col 913 (18 April 1950) [Electronic version]*.

Ainsworth-Vaughn, N. (1995). Claiming Power in the Medical Encounter: The Whirlpool Discourse. *Qualitative Health Research*, *5*(3), 270–291. doi:10.1177/104973239500500302

Ainsworth-Vaughn, N. (2001). The discourse of medical encounters. In D. Schiffrin, D. Tannen, & H. E. Hamilton (Eds.), *The Handbook of Discourse Analysis* (Chap. 23, pp. 453–469). Malden, MA: Blackwell Publishers.

Airey, C. & Erens, B. (1999). *The National Surveys of NHS Patients: General Practice 1998*. London, UK: Department of Health.

Allsop, J. (2006). Medical dominance in a changing world: The UK case. *Health Sociology Review*, *15*(5), 444–457. doi:10.5172/hesr.2006.15.5.444

Appleby, J., Robertson, R., & Taylor, E. (2016). NHS: Trends in dissatisfaction and attitudes to funding. In M. Phillips, E. Taylor, & I. Simpson (Eds.), *British Social Attitudes 33: Britain divided? public attitudes after seven years of austerity*. London, UK: NatCen Social Research.

Appleby, J. & Rosete, A. A. (2003). The NHS: Keeping up with public expectations? In A. Park, J. Curtice, K. Thomson, L. Jarvis, & C. Bromley (Eds.), *British social attitudes: The 20th report. continuity and change over two decades.* (Chap. 2, pp. 29–44). London, UK: SAGE Publications.

Bacchi, C. (2016). Problematizations in health policy. *SAGE Open*, *6*(2), 1–16. doi:10.1177/2158244016653986

Bacchi, C. L. (1999). *Women, policy and politics: The construction of policy problems*. London: SAGE Publications.

Bacchi, C. L. (2000). Policy as Discourse: What does it mean? Where does it get us? *Discourse: Studies in the Cultural Politics of Education*, *21*(1), 45–57. doi:10.1080/01596300050005493

Bacchi, C. L. (2009). *Analysing policy: What's the problem represented to be?* Frenchs Forest, NSW: Pearson Australia.

Bacchi, C. L. (2010). Taking problems apart. In M. L. Krook & S. Childs (Eds.), *Women, gender and politics: A reader* (Chap. 30, pp. 263–266). New York, USA: Oxford University Press.

Bacchi, C. L. (2012). Why study problematizations? making politics visible. *Open Journal of Political Science*, *2*(1), 1–8. doi:10.4236/ojps.2012.21001

Bacchi, C. L. (2015). The turn to problematization: Political implications of contrasting interpretive and poststructural adaptations. *Open Journal of Political Science*, *5*(1), 1–11. doi:10.4236/ojps.2015.51001

Bacchi, C. L. & Bonham, J. (2014). Reclaiming discursive practices as an analytic focus: Political implications. *Foucault Studies*, (17), 179–192.

Ball, S. J. (1990). *Politics and policy making in education: Explorations in policy sociology*. London: Routledge.

Ball, S. J. (1993). What is policy? texts, trajectories and toolboxes. *Discourse: Studies in the cultural politics of education*, *13*(2), 10–17. doi:10.1080/0159630930130203

Ball, S. J. (2015). What is policy? 21 years later: Reflections on the possibilities of policy research. *Discourse: Studies in the Cultural Politics of Education*, *36*(3), 306–313. doi:10.1080/01596306.2015.1015279

Ball, T. (1988). *Transforming political discourse: Political theory and critical conceptual history*. Oxford, UK: Basil Blackwell Ltd.

Barker, C. & Galasiński, D. (2001). *Cultural studies and discourse analysis: A dialogue on language and identity*. London, UK: SAGE Publications.

Bateman, H., Hibble, A., & Hand, C. (2000). Grounding policy development within an educational setting: an exploration. *Medical Education*, *34*(9), 769–775. doi:10.1046/j.1365-2923.2000.00628.x

BBC. (2000). *Spotting medical mistakes*. Retrieved August 27, 2015, from http://news.bbc.co.uk/1/hi/health/789056.stm

BBC. (2001a). *BBC News | HEALTH | Organ scandal background*. Retrieved January 29, 2001, from http://news.bbc.co.uk/1/hi/1136723.stm

BBC. (2001b). *NHS aims to improve patient safety*. Retrieved April 17, 2001, from http://news.bbc.co.uk/1/hi/health/1281329.stm

BBC. (2003). *BBC NEWS | Health | GMC still seen as 'out of touch'*. Retrieved September 10, 2003, from http://news.bbc.co.uk/1/hi/health/3084880.stm

BBC. (2006). *Doctors to face competence checks*. Retrieved July 14, 2006, from http://news.bbc.co.uk/1/hi/health/5177992.stm

BBC. (2016). *Junior doctors' row: The dispute explained*. Retrieved April 6, 2016, from http://www.bbc.co.uk/news/health-34775980

Bell, L. & Stevenson, H. (2006). *Education policy: Process, themes and impact*. Learning for Leadership. New York: Routledge.

Berger, P. L. & Luckmann, T. (1966). *The social construction of reality*. London, UK: Penguin Books.

Bleakley, A., Bligh, J., & Browne, J. (2011). *Medical Education for the Future: Identity, Power and Location*. Advances in Medical Education. London: Springer. doi:10.1007/978-90-481-9692-0

BMA. (2007). *Medical Service Increment for Teaching (SIFT) Funding Report*. British Medical Association. London, UK. Retrieved from http://image.guardian.co.uk/sys-files/Education/documents/2007/05/11/BMA.pdf

Boelen, C. (1994). Interlinking medical practice and medical education: Prospects for international action. *Medical Education*, *28*(s1), 82–85. doi:10.1111/j.1365-2923.1994.tb02768.x

Bonner, T. N. (1995). *Becoming a Physician: Medical education in Britain, France, Germany, and the United States, 1750–1945*. Becoming a Physician: Medical education in Britain, France, Germany, and the United States, 1750–1945. New York: Oxford University Press.

Bossing, N. L. (1952). How can the learning environment be improved? In N. L. Bossing (Ed.), *Teaching in secondary schools* (3e, pp. 423–441). Boston, MA: Houghton Mifflin Company. doi:10.1037/14494-017

Bourdieu, P. (1998). *Acts of resistance: Against the new myths of our time*. Cambridge, UK: Polity Press and The New Press.

Bourdieu, P. (1999). Language and symbolic power. In A. Jaworski & N. Coupland (Eds.), *The discourse reader* (Chap. 29, pp. 502–513). London: Routledge.

Bourdieu, P. & Eagleton, T. (1992). Doxa and common life. *New Left Review*, *I/191*, 111–121.

Bourke, A. (1997). The Internationalisation of Higher Education: The Case of Medical Education. *Higher Education Quarterly*, *51*(4), 325–346. doi:10.1111/1468-2273.00050

Boursicot, K. & Roberts, T. (2009). Widening participation in medical education: Challenging elitism and exclusion. *Higher Education Policy*, *22*(1), 19–36. doi:10.1057/hep.2008.35

Bové, P. A. (1995). Discourse. In F. Lentricchia & T. McLaughlin (Eds.), *Critical terms for literary study* (2nd ed., Chap. 4, pp. 50–65). Chicago: University of Chicago Press.

Bradbury, J. A. (1989). The policy implications of differing concepts of risk. *Science, Technology, & Human values*, *14*(4), 380–399.

Bradby, H., Gabe, J., & Bury, M. (1995). 'Sexy docs' and 'busty blondes': press coverage of professional misconduct cases brought before the General Medical Council. *Sociology of Health & Illness*, *17*(4), 458–476. doi:10.1111/1467-9566.ep10932234

Brice, J. & Corrigan, O. (2010). The changing landscape of medical education in the UK. *Medical Teacher*, *32*(9), 727–732.

Brown, B. & Baker, S. (2012). *Responsible citizens: Individuals, health and policy under neoliberalism*. London, UK: Anthem Press.

Bunniss, S. & Kelly, D. R. (2010). Research paradigms in medical education research. *Medical Education*, *44*(4), 358–366. doi:10.1111/j.1365-2923.2009.03611.x

Burnham, P., Lutz, K. G., Grant, W., & Layton-Henry, Z. (2008). *Research methods in politics* (2nd). Hampshire: Palgrave Macmillan.

Burr, V. (2003). *Social constructionism* (2nd ed.). New York, USA: Routledge.

Bury, M. R. (1986). Social constructionism and the development of medical sociology. *Sociology of Health & Illness*, *8*(2), 137–169. doi:10.1111/1467-9566.ep11340129

Buse, K., Mays, N., & Walt, G. (2005). *Making health policy* (2nd ed.). Understanding public health. Berkshire, UK: Open University Press.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. London: Routledge.

Calman, K. C., Temple, J. G., Naysmith, R., Cairncross, R. G., & Bennett, S. J. (1999). Reforming higher specialist training in the United Kingdom – a step along the continuum of medical education. *Medical Education*, *33*(1), 28–33. doi:10.1046/j.1365-2923.1999.00356.x

Cameron, D., Frazer, E., Harvey, P., Rampton, B., & Richardson, K. (1999). Power/Knowledge: The politics of social science. In A. Jaworski & N. Coupland (Eds.), *The discourse reader* (Chap. 8, pp. 141–157). London: Routledge.

CFWI. (2011). *Shape of the medical workforce: Informing medical training numbers*. Centre for Workforce Intelligence. London, UK. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507645/CfWI_informing_medical_training_numbers.pdf

Chamberlain, J. M. (2009). *Doctoring Medical Governance*. Medical Self-Regulation in Transition. New York, USA: Nova Science Publishers, Inc.

Chan, P. (2015). *Undergraduate medical education funding in the UK: Principles and effects* (Doctoral dissertation, School of Education, University of Sheffield).

Cheng, E. K.-M. (2012). *Historiography: An introductory guide*. London, UK: Bloomsbury Academic.

Chiong, W. (2007). Justifying patient risks associated with medical education. *JAMA*, *298*(9), 1046–1048. doi:10.1001/jama.298.9.1046

Clarke, E. (1966). History of British medical education. *Medical Education*, *1*(1), 7–15.

Clinton, H. R. & Obama, B. (2006). Making patient safety the centerpiece of medical liability reform. *New England Journal of Medicine*, *354*(21), 2205–2208. doi:10.1056/NEJMp068100

Codd, J. A. (1988). The construction and deconstruction of educational policy documents. *Journal of Education Policy*, *3*(3), 235–247. doi:10.1080/0268093880030303

Cohen of Birkenhead, L. (1968). Medical education in Great Britain and Ireland, 1858-1967*. *Medical Education*, *2*(2), 87–97.

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). Abingdon, Oxfordshire: Routledge.

Coldicott, Y., Pope, C., & Roberts, C. (2003). The ethics of intimate examinations – teaching tomorrow's doctors. *BMJ: British Medical Journal*, *326*(7380), 97–101.

Colebatch, H. K. (2006). What work makes policy? *Policy Sciences*, *39*(4), 309–321. doi:10.1007/s11077-006-9025-4

Colwell, C. (1997). Deleuze and Foucault: Series, event, genealogy. *Theory & Event*, *1*(2). doi:10.1353/tae.1997.0004

Cooke, L., Halford, S., & Leonard, P. (2003). *Racism in the medical profession: The experience of UK graduates*. British Medical Association.

Coplin, W. D. & O'Leary, M. K. (1987). *Effective participation in government: A guide to policy skills* (2nd ed.). New York, USA: Policy Studies Associates.

Cormac, I., Cottrell, D., Fleminger, S., & Katona, C. (1997). Core psychiatry for tomorrow's doctors. *Psychiatric Bulletin*, *21*(8), 522–524.

Cottrell, D. (1999). Recruitment, undergraduate education and the possible impact of tomorrow's doctors. *Psychiatric Bulletin*, *23*(10), 582–584.

Cradock, G. (2007). The responsibility dance: Creating neoliberal children. *Childhood*, *14*(2), 153–172. doi:10.1177/0907568207078325

Crane, J., Cary, N., Risdon, R., Green, M., & Vanezis, P. (2010). Shows how GMC is out of touch. *BMJ (Clinical research ed)*, *341*(c5999), 954.

Crilly, M., Glasziou, P., Heneghan, C., Meats, E., & Burls, A. (2009). Does the current version of 'Tomorrow's Doctors' adequately support the role of evidence-based medicine in the undergraduate curriculum? *Medical Teacher*, *31*(10), 938–944. doi:10.3109/01421590903199650

Daker-White, G., Hays, R., McSharry, J., Giles, S., Cheraghi-Sohi, S., Rhodes, P., & Sanders, C. (2015). Blame the patient, blame the doctor or blame the system? a meta-synthesis of qualitative studies of patient safety in primary care. *PloS one*, *10*(8), e0128329. doi:10.1371/journal.pone.0128329

Davis, P. (2004). Health care as a risk factor. *CMAJ*, *170*(11), 1688–1689. doi:10.1503/cmaj.1040690

Dean, M. (1999). *Governmentality : Power and rule in modern society*. London, UK: SAGE Publications.

Dean, M. (2010). *Governmentality : Power and rule in modern society* (2nd ed.). London, UK: SAGE Publications.

DeLeon, P. & Martell, C. R. (2006). The policy sciences: Past, present, and future. In B. G. Peters & J. Pierre (Eds.), *The handbook of public policy* (Chap. 2, pp. 31–48). London, UK: Sage Publications Ltd.

Department for Work and Pensions. (2013). *Helping to reduce poverty and improve social justice - Policies - GOV.UK*. Retrieved August 30, 2013, from https://www.gov.uk/government/policies/helping-to-reduce-poverty-and-improve-social-justice

Department of Health. (2016). *Up to 1,500 extra medical training places announced*. Retrieved October 4, 2016, from https://www.gov.uk/government/news/up-to-1500-extra-medical-training-places-announced

Dewar, S. & Finlayson, B. (2001). Reforming the GMC. *BMJ (Clinical research ed)*, *322*(7288), 689–690.

Dogra, N. & Williams, R. (2006). Applying policy and evidence in developing cultural diversity teaching in undergraduate medical education in the UK. *Evidence & Policy: A Journal of Research, Debate and Practice*, *2*(4), 463–478. doi:10.1332/174426406778881809

Dryzek, J. S. (1993). Policy analysis and planning: From science to argument. In F. Fischer & J. Forester (Eds.), *The argumentative turn in policy analysis and planning* (pp. 214–232). London, UK: Duke University Press.

Durning, D. (1999). The transition from traditional to postpositivist policy analysis: A role for Q-methodology. *Journal of Policy Analysis and Management*, *18*(3), 389–410. doi:10.1002/(SICI)1520-6688(199922)18:3<389::AID-PAM4>3.0.CO;2-S

Dye, T. R. (2013). *Understanding public policy* (14th ed.). Upper Saddle River, NJ: Pearson Education.

Eagles, J. M. (2005). Should the NHS revise its role in medical student education? *Scottish Medical Journal*, *50*(4), 144–147.

Edwards, N. (2012). Consultant led and delivered services. *BMJ*, *344*(e3229). doi:10.1136/bmj.e3229

Emanuel, L., Don Berwick, D., Conway, J., Combes, J., Hatlie, M., Leape, L., … Walton, M. (2008). What exactly is patient safety? In K. Henriksen, J. B. Battles, M. A. Keyes, & M. L. Grady (Eds.), *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment)*. Rockville, MD: Agency

for Healthcare Research and Quality. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK43629/

Entwistle, N. J. (1991). Approaches to learning and perceptions of the learning environment. *Higher Education*, *22*(3), 201–204. doi:10.1007/BF00132287

Esmail, A. & Roberts, C. (2013). *Independent review of the Membership of the Royal College of General Practitioners (MRCGP) examination*. University of Manchester.

Fairclough, N. (1989). *Language and Power*. Language in social life. Addison-Wesley Longman Ltd.

Fairclough, N. (1999). Linguistic and intertextual analysis within discourse analysis. In *The discourse reader* (Chap. 11, pp. 183–211). London, UK: Routledge.

Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. Oxford, UK: Routledge.

Fairclough, N. (2013). Critical discourse analysis and critical policy studies. *Critical Policy Studies*, *7*(2), 177–197. doi:10.1080/19460171.2013.798239

Fallowfield, L. & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. *The Lancet*, *363*(9405), 312–319. doi:10.1016/S0140-6736(03)15392-5

Fischer, F. & Forester, J. (1993). Editors' introduction. In F. Fischer & J. Forester (Eds.), *The argumentative turn in policy analysis and planning* (pp. 1–17). London: Duke University Press.

Flitcroft, K., Gillespie, J., Salkeld, G., Carter, S., & Trevena, L. (2011). Getting evidence into policy: The need for deliberative strategies? *Social Science & Medicine*, *72*(7), 1039–1046. doi:10.1016/j.socscimed.2011.01.034

Foucault, M. (1972). *The archaeology of knowledge*. New York: Pantheon Books.

Foucault, M. (1979). *The History of Sexuality. Volume 1: An Introduction*. New York: Pantheon Books.

Foucault, M. (1981). The order of discourse. In R. Young (Ed.), *Untying the text: A post-structuralist reader* (Chap. 3, pp. 51–78). Boston, MA: Routledge & Kegan Paul.

Foucault, M. (1982). The subject and power. *Critical inquiry*, *8*(4), 777–795.

Foucault, M. (1991a). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality* (Chap. 4, pp. 87–104). Chicago, USA: The University of Chicago Press.

Foucault, M. (1991b). Politics and the study of discourse. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality* (pp. 53–72). Chicago, USA: The University of Chicago Press.

Foucault, M. (1995). *Discipline and punish: The birth of the prison*. New York, USA: Vintage Books.

Foucault, M. (1997). *Ethics: Subjectivity and truth* (P. Rabinow, Ed.). The Essential Works of Michel Foucault, 1954-1984. New York, USA: The New Press.

Foucault, M. (1999). The incitement to discourse. In A. Jaworski & N. Coupland (Eds.), *The discourse reader* (Chap. 30, pp. 514–522). London: Routledge.

Foucault, M. & Eward, F. (1988). The concern for truth. In L. D. Kritzman (Ed.), *Michel foucault: Politics, philosophy, culture: Interviews and other writings 1977-1984* (Chap. 15, pp. 255–267). New York, USA: Routledge.

Freemantle, N., Richardson, M., Wood, J., Ray, D., Khosla, S., Shahian, D., … Pagano, D. (2012). Weekend hospitalization and additional risk of death: An analysis of inpatient data. *Journal of the Royal Society of Medicine*, *105*(2), 74–84. doi:10.1258/jrsm.2012.120009

Freire, P. (2000). *Pedagogy of the oppressed* (30th Anniversary). New York, USA: Continuum.

Gale, T. (1999). Policy Trajectories: treading the discursive path of policy analysis. *Discourse: Studies in the Cultural Politics of Education*, *20*(3), 393–407. doi:10.1080/0159630990200304

Gale, T. (2001). Critical policy sociology: historiography, archaeology and genealogy as methods of policy analysis. *Journal of Education Policy*, *16*(5), 379–393. doi:10.1080/02680930110071002

Gale, T. (2007). Realising policy: The *who* and *how* of policy production. In B. Lingard & J. Ozga (Eds.), *The RoutledgeFalmer Reader in Education Policy and Politics* (Chap. 13, pp. 221–235). Readers in Education. London: Routledge.

Galvin, R. (2002). Disturbing notions of chronic illness and individual responsibility: Towards a genealogy of morals. *Health: An interdisciplinary journal for the social study of health, illness and medicine*, *6*(2), 107–137. doi:10.1177/136345930200600201

Garland, D. (2001). *The culture of control: Crime and social order in contemporary society*. Oxford, UK: Oxford University Press.

General Medical Council. (1993). *Tomorrow's Doctors: Recommendations on undergraduate medical education*. London: General Medical Council.

General Medical Council. (2001). *Good medical practice*. London: General Medical Council.

General Medical Council. (2003). *Tomorrow's Doctors*. London: General Medical Council.

General Medical Council. (2009). *Tomorrow's Doctors: Outcomes and standards for undergraduate medical education*. London: General Medical Council.

General Medical Council. (2012). *Raising and acting on concerns about patient safety*. London: General Medical Council.

General Medical Council. (2013a). *Doctors' use of social media*. London: General Medical Council.

General Medical Council. (2013b). *Education and training standards review*. Paper presented at the meeting of the Expert Advisory Group of the GMC. Retrieved 2013, from http://www.gmc-uk.org/education/23548.asp

General Medical Council. (2013c). *GMC | Bodies awarding UK medical degrees*. Retrieved April 18, 2013, from http://www.gmc-uk.org/education/undergraduate/awarding_bodies.asp

General Medical Council. (2013d). *GMC | Education and training*. Retrieved March 30, 2012, from http://www.gmc-uk.org/education/index.asp

General Medical Council. (2013e). *GMC | The role of the GMC*. Retrieved April 18, 2013, from http://www.gmc-uk.org/about/role.asp

General Medical Council. (2013f). *Good medical practice*. London: General Medical Council.

General Medical Council. (2015a). *Outcomes for graduates (Tomorrow's Doctors)*. London: General Medical Council.

General Medical Council. (2015b). *Outcomes for provisionally registered doctors with a licence to practise (The Trainee Doctor)*. London: General Medical Council.

General Medical Council. (2015c). *Promoting excellence: Standards for medical education and training*. London: General Medical Council.

General Medical Council. (2015d). *The state of medical education and practice in the UK*. London, UK: General Medical Council.

General Medical Council. (2016a). *GMC| FAQS for UK medical students*. Retrieved July 31, 2016, from http://www.gmc-uk.org/education/undergraduate/undergraduate_faqs.asp#2whatare

General Medical Council. (2016b). *GMC | Our role*. Retrieved August 29, 2016, from http://www.gmc-uk.org/about/role.asp

General Medical Council. (2016c). *GMC | Our role approving trainers, training environments and curricula*. Retrieved September 5, 2016, from http://www.gmc-uk.org/education/29052.asp

Gewirtz, S., Dickson, M., & Power, S. (2007). Unravelling a 'spun' policy: A case study of the constitutive role of 'spin' in the educational policy process. In B. Lingard & J. Ozga (Eds.), *The RoutledgeFalmer Reader in Education Policy and Politics* (Chap. 11, pp. 178–197). Readers in Education. London: Routledge.

Goldbeck-Wood, S. (1996). Choosing tomorrow's doctors. *BMJ*, *313*(7053), 313. doi:10.1136/bmj.313.7053.313

Goldsmith, A. (2002). Policing weak states: Citizen safety and state responsibility. *Policing & Society*, *13*(1), 3–21. doi:10.1080/1043946032000050553

Goodenough, W. M., Stopford, J., Elliott, T. R., Gray, A. M. H., Hendry, J., Hill, A. V., … Vaughan, J. (1944). *Report of the inter-departmental committee on medical schools*. London: HMSO.

Goodin, R. E., Rein, M., & Moran, M. (2006). The public and its policies. In M. Moran, M. Rein, & R. E. Goodin (Eds.), *The oxford handbook of public policy* (Chap. 1, pp. 3–35). Oxford Handbooks of Political Science. Oxford, UK: Oxford University Press.

Goodwin, N. (1996). Governmentality in the Queensland Department of Education: Policies and the management of schools. *Discourse: Studies in the Cultural Politics of Education*, *17*(1), 65–74. doi:10.1080/0159630960170105

Goodwin, S. (2011). Analysing policy as discourse: Methodological advances in policy analysis. In L. Markauskaite, P. Freebody, & J. Irwin (Eds.), *Methodological choice and design: Scholarship, policy and practice in social and educational research* (Chap. 15, pp. 167–180). London, UK: Springer Science+Business Media B.V. doi:10.1007/978-90-481-8933-5

Gordon, I., Lewis, J., & Young, K. (1997). Perspectives on policy analysis. In M. Hill (Ed.), *The policy process: A reader* (pp. 5–9). Essex, UK: Prentice Hall.

Gottweis, H. (2003). Theoretical strategies of poststructuralist policy analysis: Towards an analytics of government. In M. A. Hager & H. Wagenaar (Eds.), *Deliberative policy analysis: Understanding governance in the network society* (Chap. 9, pp. 247–265). Cambridge, UK: Cambridge University Press.

Gottweis, H. (2006). Argumentative policy analysis. In B. G. Peters & J. Pierre (Eds.), *Handbook of public policy* (Chap. 27, pp. 461–479). London, UK: Sage Publications Ltd.

Gottweis, H. & Fischer, F. (2012). *The argumentative turn revisited : Public policy as communicative practice*. Durham, UK: Duke University Press.

Grant, J. (2012). *Medical education: An induction into the profession*. Retrieved June 11, 2012, from http://www.ucl.ac.uk/medicalschool/postgraduate/events/mededconference11062012/JG-UCL-Induction-in-the-profession.pdf

Gray, G. C. (2009). The responsibilization strategy of health and safety: Neo-liberalism and the reconfiguration of individual responsibility for risk. *The British Journal of Criminology*, *49*(3), 326–342. doi:10.1093/bjc/azp004

Gray, P. (2005). The politics of risk and young offenders' experiences of social exclusion and restorative justice. *British Journal of Criminology*, *45*(6), 938–957. doi:10.1093/bjc/azi018

Greenbank, P. (2003). The role of values in educational research: The case for reflexivity. *British Educational Research Journal*, *29*(6), 791–801.

Haddara, W. & Lingard, L. (2013). Are We All on the Same Page? A Discourse Analysis of Interprofessional Collaboration. *Academic medicine : journal of the Association of American Medical Colleges*, *88*(10), 1509–1515. doi:10.1097/ACM.0b013e3182a31893

Hajer, M. A. (1993). Discourse coalitions and the institutionalization of practice: The case of acid rain in Britain. In F. Fischer & J. Forester (Eds.), *The argumentative turn in policy analysis and planning* (Chap. 2, pp. 43–76). London: Duke University Press.

Halliday, M. A. K. (2009). *The essential Halliday* (J. J. Webster, Ed.). London, UK: Continuum.

Hammick, M. (1995). A critical analysis of the British Government's policy to create an internal market in non-medical health care education with specific reference to radiography. *Higher Education Policy*, *8*(4), 42–47. doi:10.1057/hep.1995.65

Harden, R., Davis, M., & Crosby, J. (1997). The new Dundee medical curriculum: A whole that is greater than the sum of the parts. *Medical education*, *31*(4), 264–271. doi:10 . 1111 / j . 1365 - 2923 . 1997 . tb02923.x

Harden, R. M. & Gleeson, F. (1979). Assessment of clinical competence using an objective structured clinical examination (OSCE). *Medical education*, *13*(1), 39–54. doi:10 . 1111 / j . 1365 - 2923 . 1979 . tb00918.x

Hargie, O., Dickson, D., Boohan, M., & Hughes, K. (1998). A survey of communication skills training in UK Schools of Medicine: present practices and prospective proposals. *Medical Education*, *32*(1), 25–34. doi:10.1046/j.1365-2923.1998.00154.x

Hartas, D. (2010). Educational research and inquiry: Key issues and debates. In D. Hartas (Ed.), *Educational research and inquiry: Qualitative and quantitative approaches* (Chap. 1, pp. 13–32). London: Continuum.

Harvey, L. (2010). The Accreditation and Quality Processes of the General Medical Council in the UK. In D. D. Dill & M. Beerkens (Eds.), *Public policy for academic quality: Analyses of innovative policy instruments* (pp. 249–276). London: Springer.

Haworth, K. (2006). The dynamics of power and resistance in police interview discourse. *Discourse & Society*, *17*(6), 739–759. doi:10.1177/0957926506068430

HEFCE. (2016). *National Student Survey – Higher Education Funding Council for England*. Retrieved August 31, 2016, from http://www.hefce.ac.uk/lt/nss/

Henry, M. (1993). WHAT IS POLICY? A response to Stephen Ball. *Discourse: Studies in the Cultural Politics of Education*, *14*(1), 102–105. doi:10.1080/0159630930140110

Heyman, B. (2010). The social construction of health risks. In B. Heyman, M. Shaw, A. Alaszewski, & M. Titterton (Eds.), *Risk, safety and clinical practice: Health care through the lens of risk* (Chap. 2, pp. 37–58). Oxford, UK: Oxford University Press.

Hill, D. (2014). Education, neoliberalism, neoconservatism, and class struggle in Britain and Europe. In P. W. Orelus, C. S. Malott, & R. Pacheco (Eds.), *Colonized schooling exposed: Progressive voices for transformative educational and social change* (Chap. 14, pp. 182–198). New York, USA: Routledge.

Hilton, S. & Southgate, L. (2007). Professionalism in medical education. *Teaching and Teacher Education*, *23*(3), 265–279. doi:10.1016/j.tate.2006.12.024

Historiography. (2017). *Oxforddictionaries.com*. Retrieved March 17, 2017, from https://en.oxforddictionaries.com/definition/historiography

Hitchen, L. (2007). Blame culture is still a problem in tackling patient safety. *BMJ*, *335*(7631), 1172. doi:10.1136/bmj.39415.492164.DB

Hodges, B. D. (2012). The shifting discourses of competence. In B. D. Hodges & L. Lingard (Eds.), *The question of competence: Reconsidering medical education in the twenty-first century* (Chap. 1, pp. 14–41). New York, USA: Cornell University Press.

Hogwood, B. W., Gunn, L. A., & Archibald, S. (1984). *Policy analysis for the real world*. Oxford, UK: Oxford University Press.

Howarth, D. (2010). Power, discourse, and policy: Articulating a hegemony approach to critical policy studies. *Critical Policy Studies*, *3*(3-4), 309–335. doi:10.1080/19460171003619725

Howarth, D. & Griggs, S. (2012). Poststructuralist policy analysis: Discourse, hegemony and critical explanation. In H. Gottweis & F. Fischer (Eds.), *The argumentative turn revisited : Public policy as communicative practice*. Durham, UK: Duke University Press.

HSCIC. (2013). *A guide to confidentiality in health and social care*. Health and Social Care Information Centre (HSCIC).

Hu, W. C., Thistlethwaite, J. E., Weller, J., Gallego, G., Monteith, J., & McColl, G. J. (2015). It was serendipity: A qualitative study of academic careers in medical education. *Medical education*, *49*(11), 1124–1136. doi:10.1111/medu.12822

Hudson, J. & Lowe, S. (2004). *Understanding the policy process: Analysing welfare policy and practice*. Bristol, UK: The Policy Press.

Hunt, J. (2015). *Letter to Sarah Wollaston MP*. Retrieved July 18, 2016, from http://www.parliament.uk/documents/commons-committees/Health/Correspondence/2015-16/Letter-from-the-Secretary-of-State-for-Health-to-the-Chair-on-seven-day-NHS-hospital-services.pdf

Hurwitz, B. & Vass, A. (2002). What's a good doctor, and how can you make one? *BMJ (Clinical research ed)*, *325*(7366), 667–668. doi:10.1136/bmj.325.7366.667

Huxham, G. J., Lipton, A., Hamilton, D., & Chant, D. (1989). What 'makes' a good doctor? *Medical Education*, *23*(1), 3–13.

Hyatt, D. (2013). The critical higher education policy discourse analysis framework. In J. Huisman & M. Tight (Eds.), *Theory and method of higher education research* (Chap. 3, Vol. 9, pp. 41–59). International perspectives on higher education research. Emerald Group Publishing.

Hyland, K. (2013). Introduction. In K. Hyland (Ed.), *Discourse studies reader: Essential excerpts* (Chap. 1, pp. 1–7). Bloomsbury Discourse. London, UK: Bloomsbury Academic.

Iedema, R., Piper, D., & Manidis, M. (2015). A brief history of communication in healthcare. In R. Iedema, D. Piper, & M. Manidis (Eds.), *Communicating quality and safety in health care* (Chap. 2, pp. 17–34). Melbourne, Australia: Cambridge University Press.

Ipsos MORI. (2015). *The NHS remains the most important issue facing Britain*. Retrieved February 27, 2015, from https://www.ipsos-mori.com/researchpublications/researcharchive/3535/The-NHS-remains-the-most-important-issue-facing-Britain.aspx

Irvine, D. (1997). Problem doctors in the UK: Role of the General Medical Council. In P. Lens & G. van der Wal (Eds.), *Problem doctors: A conspiracy of silence* (Chap. 7, pp. 111–122). Amsterdam, Netherlands: IOS Press.

Irvine, D. (2006). A short history of the General Medical Council. *Medical Education*, *40*(3), 202–211. doi:10.1111/j.1365-2929.2006.02397.x

Kaba, R. & Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery*, *5*(1), 57–65. doi:10.1016/j.ijsu.2006.01.005

Kaffash, J. (2014). *GMC to introduce new exam for all medical graduates to practise in the UK*. Retrieved September 26, 2014, from http://www.pulsetoday.co.uk/your-practice/practice-topics/education/gmc-to-introduce-new-exam-for-all-medical-graduates-to-practise-in-the-uk/20008019.fullarticle

Kamler, B., Comber, B., & Cook, J. (1997). Introduction: Critical discourse analysis, or life after the linguistic turn. *Discourse: Studies in the Cultural Politics of Education*, *18*(3), 325–327. doi:10.1080/0159630970180301

Keighley, B. (2004). The General Medical Council: an inside view. *The British Journal of General Practice*.

Kelley, M. (2005). Limits on patient responsibility. *Journal of Medicine and Philosophy*, *30*(2), 189–206.

Kleijnen, J., Dolmans, D., Muijtjens, A., Willems, J., & Van Hout, H. (2009). Organisational values in higher education: Perceptions and preferences of staff. *Quality in Higher Education*, *15*(3), 233–249. doi:10.1080/13538320903343123

Knapp, R. M. (2002). Complexity and uncertainty in financing graduate medical education. *Academic medicine : journal of the Association of American Medical Colleges*, *77*(11), 1076–1083.

Kuper, A., Whitehead, C., & Hodges, B. D. (2013). Looking back to move forward: Using history, discourse and text in medical education research: AMEE Guide No. 73. *Medical Teacher*, *35*(1), e849–e860. doi:10.3109/0142159X.2012.748887

Kyriakides, C. & Virdee, S. (2003). Migrant labour, racism and the british national health service. *Ethnicity & health*, *8*(4), 283–305. doi:10.1080/1355785310001631731

Lang, A., Edwards, N., & Fleiszer, A. (2008). Safety in home care: A broadened perspective of patient safety. *International Journal for Quality in Health Care*, *20*(2), 130–135. doi:10.1093/intqhc/mzm068

Lather, P. (1996). Troubling clarity: The politics of accessible language. *Harvard Educational Review*, *66*(3), 525–545.

Leach, B. & Donnelly, L. (2012). *Revealed: 3 in 4 of Britain's danger doctors are trained abroad*. Retrieved December 29, 2012, from http://www.telegraph.co.uk/news/health/news/9771022/Revealed-3-in-4-of-Britains-danger-doctors-are-trained-abroad.html

Leahy, M., Cullen, W., & Bury, G. (2003). ‘‘What makes a good doctor?" a cross sectional survey of public opinion. *Irish Medical Journal*, *96*(2), 38–41.

Leinster, S. J. (2004). Medical schools: Are we paying for education or for technical training? *Journal of the Royal Society of Medicine*, *97*(1), 3–5.

Liebenberg, L., Ungar, M., & Ikeda, J. (2015). Neo-liberalism and responsibilisation in the discourse of social service workers. *British Journal of Social Work*, *45*(3), 1006–1021. doi:10.1093/bjsw/bct172

Lindblom, C. E. (1959). The science of “Muddling Through”. *Public administration review*, *19*(2), 79–88.

Lindblom, C. E. (1979). Still Muddling, Not yet through. *Public administration review*, *39*(6), 517–526.

Lingard, B. & Ozga, J. (2007). Introduction: Reading education policy and politics. In B. Lingard & J. Ozga (Eds.), *The RoutledgeFalmer Reader in Education Policy and Politics* (Chap. 1, pp. 1–8). Readers in Education. Oxford: Routledge.

Lingard, L. (2009). What we see and don't see when we look at 'competence': Notes on a god term. *Advances in health sciences education : theory and practice*, *14*(5), 625–628. doi:10.1007/s10459-009-9206-y

Lomas, J. (2000). Connecting research and policy. *Canadian Journal of Policy research*, *1*, 140–144.

Lynch, R. A. (2011). Foucault's theory of power. In D. Taylor (Ed.), *Michel Foucault: Key Concepts* (Chap. 1, pp. 13–26). Durham: Acumen Publishing Ltd.

Lynn, L. E. (1999). A place at the table: Policy analysis, its postpositive critics, and the future of practice. *Journal of Policy Analysis and Management*, *18*(3), 411–425. doi:10.1002/(SICI)1520-6688(199922)18:3<411::AID-PAM5>3.0.CO;2-G

Macdonell, D. (1986). *Theories of discourse: An introduction*. Oxford, UK: Basil Blackwell Ltd.

MacDougall, J. & Drummond, M. J. (2005). The development of medical teachers: An enquiry into the learning histories of 10 experienced medical teachers. *Medical Education*, *39*(12), 1213–1220. doi:10.1111/j.1365-2929.2005.02335.x

MacLure, M. (2003). *Discourse in educational and social research*. Buckingham, UK: Open University Press.

Maguire, M., Hoskins, K., Ball, S. J., & Braun, A. (2011). Policy discourses in school texts. *Discourse: Studies in the Cultural Politics of Education*, *32*(4), 597–609. doi:10.1080/01596306.2011.601556

Malterud, K. (2001). The art and science of clinical knowledge: Evidence beyond measures and numbers. *The Lancet*, *358*(9279), 397–400. doi:10.1016/S0140-6736(01)05548-9

Mann, K. V. (2010). Theoretical perspectives in medical education: past experience and future possibilities. *Medical Education*, *45*(1), 60–68. doi:10.1111/j.1365-2923.2010.03757.x

Mann, M. (1986). *The sources of social power: A history of power from the beginning to AD 1760*. Cambridge, UK: Cambridge University Press.

Mann, M. & Haugaard, M. (2011). Reflections on the sources of power. *Journal of Political Power*, *4*(2), 169–178. doi:10.1080/2158379X.2011.589258

Marchant, R. (2013). *Approving educational environments*. General Medical Council. London, UK.

Marsh, S. (2016). *'I blame Jeremy Hunt, not junior doctors': Patients affected by the strike*. Retrieved April 26, 2015, from https://www.theguardian.com/uk-news/2016/apr/26/jeremy-hunt-not-junior-doctors-patients-show-support-for-all-out-strike

Mathers, J., Sitch, A., Marsh, J. L., & Parry, J. (2011). Widening access to medical education for under-represented socioeconomic groups: Population based cross sectional analysis of UK data, 2002-6. *BMJ*, *342*, d918. doi:10.1136/bmj.d918

Maxwell, S. & Walley, T. (2003). Teaching safe and effective prescribing in UK medical schools: A core curriculum for tomorrow's doctors. *British journal of clinical pharmacology*, *55*(6), 496–503.

McCulloch, G. (2004). *Documentary research: In education, history and the social sciences*. Social Research and Educational Studies. London, UK: Routledge.

McGaghie, W. C., Issenberg, S. B., Cohen, E. R., Barsuk, J. H., & Wayne, D. B. (2011). Does simulation-based medical education with deliberate practice yield better results than traditional clinical education? a meta-analytic comparative review of the evidence. *Academic medicine: journal of the Association of American Medical Colleges*, *86*(6), 706–711. doi:10.1097/ACM.0b013e318217e119

McLachlan, J. C., Bligh, J., Bradley, P., & Searle, J. (2004). Teaching anatomy without cadavers. *Medical education*, *38*(4), 418–424. doi:10.1046/j.1365-2923.2004.01795.x

McManus, I., Richards, P., Winder, B., Sproston, K., & Vincent, C. (1993). The changing clinical experience of British medical students. *The Lancet*, *341*(8850), 941–944. doi:10.1016/0140-6736(93)91225-B

Medical Protection Society. (2008). Memorandum by the Medical Protection Society. In *Patient safety: Written evidence* (Ev 36 –Ev 44). London, UK: The Stationery Office Limited.

Menasco-Davis, L. (2014). *Policy analysis of graduate medical education policies and funding in texas* (Master's thesis, The University of Texas School of Public Health).

Merrison, A. (1975). *Report of the committee of inquiry into the regulation of the medical profession*. HM Stationery Office.

Miller, P. & Rose, N. (2008). *Governing the present: Administering economic, social and personal life*. Cambridge, UK: Polity Press.

Millis, J. S. (1971). *A rational public policy for medical education and its financing.* Cleveland, OH: National Fund for Medical Education.

Mills, S. (2004). *Discourse* (2nd ed.). The New Critical Idiom. London: Routledge.

Monkhouse, W. & Farrell, T. (1999). Tomorrow's doctors: Today's mistakes? *Clinical Anatomy*, *12*(2), 131–134. doi:10.1002/(SICI)1098-2353(1999)12:2%3C131::AID-CA9%3E3.0.CO;2-L

Moonesinghe, S., Lowery, J., Shahi, N., Millen, A., & Beard, J. (2011). Impact of reduction in working hours for doctors in training on postgraduate medical education and patients outcomes: Systematic review. *BMJ*, *342*, d1580. doi:10.1136/bmj.d1580

Moran, M. (2006). Health policy. In B. G. Peters & J. Pierre (Eds.), *Handbook of public policy* (Chap. 12, pp. 219–230). London, UK: Sage Publications Ltd.

Munger, M. C. (2000). *Analyzing policy: Choices, conflicts and practices*. New York, USA: W. W. Norton and Company.

Musick, D. W. (1998). Policy analysis in medical education: A structured approach. *Medical Education Online*, *3*(2), 1–14. Retrieved from http://med-ed-online.net/index.php/meo/article/view/4296/4487

National Academy of Sciences. (2000). *To err is human: Building a safer health system* (L. T. Kohn, J. M. Corrigan, & M. S. Donaldson, Eds.). Washington, DC: National Academy Press.

National Health Service. (2016). *The principles and values of the NHS in England – NHS Values*. Retrieved August 31, 2016, from http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx

Nicolson, M. & McLaughlin, C. (1987). Social constructionism and medical sociology: A reply to MR Bury. *Sociology of Health & Illness*, *9*(2), 107–126. doi:10.1111/j.1467-9566.1987.tb00307.x

Nigam, A. (1998). 'Right to work': Reading 'rights' through discourse on 'work'. *Economic and Political Weekly*, *33*(5), PE16–PE24.

Nudzor, H. (2009). What of "policy", a problem–solving definition or a process conceptualisation. *Educational futures*, *2*(1), 85–96.

Osgood, V. (2015). *New medical education and training standards*. General Medical Council. London, UK.

Ovseiko, P. V. & Buchan, A. M. (2011). Postgraduate medical education in england: 100 years of solitude. *The Lancet*, *378*(9808), 1984–1985.

Ozga, J. (2000). *Policy research in educational settings: Contested terrain*. Doing qualitative research in educational settings. Buckingham, UK: Open University Press.

Ozga, J. (1990). Policy Research and Policy Theory: a comment on Fitz and Halpin 1. *Journal of Education Policy*, *5*(4), 359–362. doi:10.1080/0268093900050405

Padaki, V. (2000). Coming to grips with organisational values. *Development in Practice*, *10*(3-4), 420–435. doi:10.1080/09614520050116578

Page, E. C. (2006). The origins of policy. In M. Moran, M. Rein, & R. E. Goodin (Eds.), *The oxford handbook of public policy* (Chap. 10, pp. 205–225). Oxford Handbooks of Political Science. Oxford, UK: Oxford University Press.

Palaoğlu, Ö., Demirören, M., Aytuğ-Koşan, A. M., & Kemahli, S. (2012). Core curriculum policy analysis in medical education. *AMEE MedEdPublish*, *1*(1).

Palmer, C. & Murcott, T. (2011). 'All news is bad news': Patient safety in the news media. In E. Rowley & J. J. Waring (Eds.), *A socio-cultural perspective on patient safety*. Surrey, UK: Ashgate.

Park, S. (2012). The industrialisation of medical education? Exploring neoliberal influences within Tomorrow's Doctors Policy 2009. In M. Lall (Ed.), *Policy, discourse and rhetoric: How new labour challenged social justice and democracy* (pp. 121–140). Rotterdam, The Netherlands: Springer. doi:10.1007/978-94-6091-817-9_7

Parker, I. (1990). Discourse: Definitions and contradictions. *Philosophical Psychology*, *3*(2-3), 187–204. doi:10.1080/09515089008572998

Parsons, W. (2002). From muddling through to muddling up. Evidence based policy making and the modernisation of British Government. *Public Policy and Administration*, *17*(3), 43–60. doi:10.1177/095207670201700304

Patel, M. S., Davis, M. M., & Lypson, M. L. (2011). Advancing Medical Education by Teaching Health Policy. *The New England journal of medicine*, *364*(8), 695–697. doi:10.1056/NEJMp1009202

Paton, G. (2009). *Oxford and Cambridge introduce new entrance tests*. Retrieved November 15, 2009, from http://www.telegraph.co.uk/education/6561399/Oxford-and-Cambridge-introduce-new-entrance-tests.html

Peters, D., Lynch, S., Manning, C., Lewith, G., & Pommerening, D. (2016). *The day after Tomorrow's Doctors: UK undergrad medical student resilience symposium*. University of Westminster.

Pickering, W. G. (1956). The purpose of medical education. *British Medical Journal*, *2*(4985), 113–116.

Platt, J. (1981). Evidence and proof in documentary research: 1: Some specific problems of documentary research. *The Sociological Review*, *29*(1), 31–52.

Pollock, K. (2006). Policy as outcome: Inequities generated from unintended policy outcomes. *Canadian and International Education / Education canadienne et internationale: 35*(2), 35–47.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. doi:10.1037/0022-0167.52.2.126

Portner, P. H. (2005). *What is meaning? fundamentals of formal semantics*. Fundamentals of linguistics. Oxford, UK: Blackwell Publishing Ltd.

Potter, S. J. & McKinlay, J. B. (2005). From a relationship to encounter: An examination of longitudinal and lateral dimensions in the doctor–patient relationship. *Social science & medicine*, *61*(2), 465–479. doi:10.1016/j.socscimed.2004.11.067

Powell, M. (1997). Socialism and the British National Health Service. *Health Care Analysis*, *5*(3), 187–194. doi:10.1007/BF02678377

Powis, D., Hamilton, J., & Gordon, J. (2004). Are graduate entry programmes the answer to recruiting and selecting tomorrow's doctors? *Medical Education*, *38*(11), 1147–1153.

Poynter, F. N. L. (1958). The centenary of the General Medical Council. *British Medical Journal*, *2*(5107), 1245–1248.

Press Association. (2016). *'World class emergency care' during junior doctors' strike, says consultant*. Retrieved April 26, 2016, from http://www.dailymail.co.uk/wires/pa/article-3558586/World-class-emergency-care-junior-doctors-strike-says-consultant.html

Prunty, J. J. (1985). Signposts for a critical educational policy analysis. *Australian Journal of Education*, *29*(2), 133–140.

Rees, L. & Jolly, B. (1998). Medical education into the next century. In B. Jolly & L. Rees (Eds.), *Medical education in the Millenium* (Chap. 9, pp. 245–259). Oxford, UK: Oxford University Press.

Rethans, J.-J., van Leeuwen, Y., Drop, R., van der Vleuten, C., & Sturmans, F. (1990). Competence and performance: Two different concepts in the assessment of quality of medical care. *Family Practice*, *7*(3), 168–174. doi:10.1093/fampra/7.3.168

Richardson, J. (2006). Policy-making in the EU. In J. Richardson (Ed.), *European union: Power and policy-making* (Chap. 1, pp. 3–23). Abingdon, Oxford: Routledge.

Roberts, A., Marshall, L., & Charlesworth, A. (2012). *A decade of austerity? the funding pressures facing the NHS from 2010/11 to 2021/22*. Nuffield Trust. London, UK.

Roberts, C. & Sarangi, S. (2005). Theme-oriented discourse analysis of medical encounters. *Medical Education*, *39*(6), 632–640.

Roberts, C., Wass, V., Jones, R., Sarangi, S., & Gillett, A. (2003). A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students. *Medical Education*, *37*(3), 192–201. doi:10.1046/j.1365-2923.2003.01443.x

Roberts, M. (2016). *Bereaved families 'let down by NHS'*. Retrieved April 6, 2016, from http://www.bbc.co.uk/news/health-38287014

Rose, N. & Miller, P. (1992). Political power beyond the state: Problematics of government. *The British Journal of Sociology*, *43*(2), 173–205.

Roulstone, A. (2014). Disability and social policy. In H. Bochel & G. Daly (Eds.), *Social policy* (3e, Chap. 18, pp. 425–448). Oxford, UK: Routledge.

Royal College of General Practitioners. (2016). *Patient safety toolkit*. Retrieved August 30, 2016, from http://www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety.aspx

Russell, B. (2010). *Patient safety. Hansard, HL Deb vol 507 col 324 - 360 (18 March 2010) [Electronic version]*.

Saarinen, T. (2008). Position of text and discourse analysis in higher education policy research. *Studies in Higher Education*, *33*(6), 719–728. doi:10.1080/03075070802457090

Salter, B. (2001). Who rules? the new politics of medical regulation. *Social Science & Medicine*, *52*(6), 871–883. doi:10.1016/S0277-9536(00)00190-8

Salter, B. (2003). Patients and doctors: Reformulating the UK health policy community? *Social science & medicine*, *57*(5), 927–936. doi:10.1016/S0277-9536(02)00461-6

Salter, B. (2007). Governing UK medical performance: A struggle for policy dominance. *Health Policy*, *82*(3), 263–275. doi:10.1016/j.healthpol.2006.10.004

Samanta, A. & Samanta, J. (2004). Regulation of the medical profession: Fantasy, reality and legality. *Journal of the Royal Society of Medicine*, *97*(5), 211–218.

Scheurich, J. J. (1994). Policy archaeology: A new policy studies methodology. *Journal of Education Policy*, *9*(4), 297–316. doi:10.1080/0268093940090402

Schofield, S. J., Bradley, S., Macrae, C., Nathwani, D., & Dent, J. (2010). How we encourage faculty development. *Medical Teacher*, *32*(11), 883–886. doi:10.3109/0142159X.2010.506564

Schram, S. F. (2015). *The return of ordinary capitalism: Neoliberalism, precarity, occupy*. Oxford, UK: Oxford University Press.

Schwartz, M. D. (2012). The US primary care workforce and graduate medical education policy. *JAMA*, *308*(21), 2252–2253. doi:10.1001/jama.2012.77034

Scollon, R. (1998). *Mediated discourse as social interaction: A study of news discourse*. Oxford, UK: Addison-Wesley Longman Group Ltd.

Scott, J. C. (1990). *A matter of record*. Documentary Sources in Social Research. Cambridge, UK: Polity Press.

Shattock, M. (2006). Policy drivers in UK higher education in historical perspective: 'inside out', 'outside in' and the contribution of research. *Higher Education Quarterly*, *60*(2), 130–140.

Shirley, J. L. & Padgett, S. M. (2006). An analysis of the discourse of professionalism. In D. Wear & J. M. Aultman (Eds.), *Professionalism in medicine: Critical perspectives* (Chap. 2, pp. 24–42). New York, USA: Springer.

Sikes, P. (2004). Methodology, procedures and ethical concerns. In C. Opie (Ed.), *Doing educational research: A guide for first-time researchers* (pp. 15–33). London: Sage.

Sinclair, D. C. (1957). British medical education and the General Medical Council. *Journal of medical education*, *32*(1), 26–29.

Singh, S. P., Baxter, H., Standen, P., & Duggan, C. (1996). Tomorrow's doctors: Has the new curriculum changed attitudes to psychiatry? *European Psychiatry*, *11*(Supplement 4), 398s. doi:10.1016/0924-9338(96)89297-2

Smith, R. (1989). Profile of the GMC: The day of judgement comes closer. *BMJ*, *298*(6682), 1241–1244.

Smith, R. (1993). GMC in the dock again. *BMJ*, *306*(6870), 82.

Smith, R. (1997). All doctors are problem doctors. *BMJ*, *314*(7084), 841.

Soothill, K. & Wilson, D. (2005). Theorising the puzzle that is Harold Shipman. *Journal of Forensic Psychiatry & Psychology*, *16*(4), 685–698. doi:10.1080/14789940500282467

Stacey, M. (1992). For public or profession? – The new GMC performance procedures. *BMJ: British Medical Journal*, *305*(6861), 1085–1087.

Steele, K. (2011). Selecting tomorrow's doctors. *Ulster Medical Journal*, *80*(2), 62–67.

Steinberg, B. E., Goldenberg, N. M., Fairn, G. D., Kuebler, W. M., Slutsky, A. S., & Lee, W. L. (2016). Is basic science disappearing from medicine? The decline of biomedical research in the medical literature. *The FASEB Journal*, *30*(2), 515–518. doi:10.1096/fj.15-281758

Steinert, Y. (2008). *From teacher to medical educator: The spectrum of medical education.* Centre for Medical Education, McGill University. Montreal, Canada.

Steinert, Y. (2013). The problem learner: Whose problem is it? AMEE Guide No. 76. *Medical teacher*, *35*(4), e1035–e1045. doi:10.3109/0142159X.2013.774082

Stephenson, L. & Stephenson, T. (2010). Selecting tomorrow's doctors – not a level playing field. *BMJ*, *341*, 996–996.

Sutton, E., Eborall, H., & Martin, G. (2015). Patient involvement in patient safety: Current experiences, insights from the wider literature, promising opportunities? *Public Management Review*, *17*(1), 72–89. doi:10.1080/14719037.2014.881538

Svansoe, V. L. (2013). Patient safety without the blame game. *BMJ*, *347*, f4615. doi:10.1136/bmj.f4615

Swanwick, T. & Buckley, G. (2010). Introduction: Understanding Medical Education. In T. Swanwick (Ed.), *Understanding medical education: Evidence, theory and practice* (pp. xv–xviii). West Sussex: Wiley-Blackwell.

Sykes, S. (2011). Policy: What is it? how is it made? In E. Porter & L. Coles (Eds.), *Policy and strategy for improving health and wellbeing* (Chap. 1, pp. 1–20). Exeter, UK: Learning Matters Ltd.

Taylor, S., Rizvi, F., Lingard, B., & Henry, M. (1997). *Educational policy and the politics of change*. Oxford: Routledge.

The Health and Education National Strategic Exchange. (2012). *Review of medical and dental school intakes in England*. The Health and Education National Strategic Exchange.

The National Archives. (2005). *The National Archives Website : Discovery: JA 10/1 : Official website of The Shipman Inquiry*. Retrieved August 27, 2015, from http://discovery.nationalarchives.gov.uk/details/r/C11287085

Thomas, M., Burt, M., & Parkes, J. (2010). The emergence of evidence-based practice. In J. McCcarthy & P. Rose (Eds.), *Values-based health and social care: Beyond evidence-based practice* (Chap. 1, pp. 3–24). London, UK: Sage Publications Ltd.

Thompson, G. (2007). *Responsibility and neo-liberalism*. Retrieved from https://www.opendemocracy.net/article/responsibility_and_neo_liberalism

Thompson, R. & Turner-Warwick, M. (2016). The NHS could do better. *Journal of the Royal Society of Medicine*. doi:10.1177/0141076816644120

Thomson, A. P. (1958). The influence of the General Medical Council on education. *British Medical Journal*, *2*(5107), 1248–1250.

Times Higher Education. (2016). *TIMES HIGHER EDUCATION WORLD UNIVERSITY RANKINGS*. Retrieved August 31, 2016, from https://www.timeshighereducation.com/world-university-rankings/2016/subject-ranking/clinical-pre-clinical-health-0#!/page/0/length/25/sort_by/rank_label/sort_order/asc/cols/rank_only

Todd, A. & Royal Commission on Medical Education 1965-68. (1968). *Royal commission on medical education 1965-68: Report*. HM Stationery Office.

Torjman, S. (2005). *What is Policy?* Ontario, Canada: Caledon Institute of Social Policy.

Towle, A. (1998). The aims of the curriculum: Education for health needs in 2000 and beyond. In B. Jolly & L. Rees (Eds.), *Medical education in the Millenium* (Chap. 1, pp. 3–18). Oxford, UK: Oxford University Press.

van Dijk, T. A. (1996). Discourse, power and access. In C. R. Caldas-Coulthard & M. Coulthard (Eds.), *Texts and practices: Readings in critical discourse analysis* (pp. 84–104). London, UK: Routledge.

van Dijk, T. A. (1997). The study of discourse. In T. A. van Dijk (Ed.), *Discourse as structure and process* (Chap. 1, pp. 1–34). London, UK: SAGE Publications.

Van Melle, E., Lockyer, J., Curran, V., Lieff, S., St Onge, C., & Goldszmidt, M. (2014). Toward a common understanding: Supporting and promoting education scholarship for medical school faculty. *Medical education*, *48*(12), 1190–1200. doi:10.1111/medu.12543

Vander Linde, S. H. (1989). *Decentralized medical education and the physician's labor supply decision: A policy analysis of indiana's system for statewide medical education* (Doctoral dissertation, University of Notre Dame).

Vedung, E. (2006). Evaluation research. In B. G. Peters & J. Pierre (Eds.), *Handbook of public policy* (Chap. 23, pp. 397–416). London, UK: Sage Publications Ltd.

Vincent, C. A. & Coulter, A. (2002). Patient safety: What about the patient? *Quality and Safety in Health Care*, *11*(1), 76–80. doi:10.1136/qhc.11.1.76

Vining, A. R. & Weimer, D. L. (2006). Efficiency and cost-benefit analysis. In B. G. Peters & J. Pierre (Eds.), *Handbook of public policy* (Chap. 24, pp. 417–432). London, UK: Sage Publications Ltd.

Waddington, I. (1990). The movement towards the professionalisation of medicine. *BMJ*, *301*(6754), 688–690.

Wagenaar, H. (2011). *Meaning in action: Interpretation and dialogue in policy analysis*. London, UK: Taylor & Francis.

Waitzkin, H. (1984). Doctor-patient communication: Clinical implications of social scientific research. *JAMA: the Journal of the American Medical Association*, *252*(17).

Waitzkin, H. (1989). A critical theory of medical discourse: ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior*, *30*(2), 220–239.

Walker, J. (2009). A window of opportunity for critical policy analysis in education? In R. Desjardins & K. Rubenson (Eds.), *Research of vs research for education policy: In an era of transnational policy-making* (Chap. 6, pp. 85–104). VDM Verlag.

Walker, R. M. (1965). *Medical education in Britain*. London: Nuffield Provincial Hospitals Trust.

Walsh, K. (2014). Cost and value in medical education – what we can learn from the past? *Journal of the Royal College of Physicians of Edinburgh*, *44*(4), 324–327. doi:10.4997/JRCPE.2014.417

Walton, G. (2010). The problem trap: Implications of policy archaeology methodology for anti‐bullying policies. *Journal of Education Policy*, *25*(2), 135–150. doi:10.1080/02680930903428630

Wang, J. (2006). Questions and the exercise of power. *Discourse & Society*, *17*(4), 529–548. doi:10.1177/0957926506063127

Waring, J. J. (2009). Constructing and re-constructing narratives of patient safety. *Social Science & Medicine*, *69*(2009), 1722–1731. doi:10.1016/j.socscimed.2009.09.052

Wear, A. (2000). *Knowledge and practice in English Medicine, 1550–1680*. Cambridge: Cambridge University Press.

Weatherall, D. J. (1991). The physician scientist: An endangered but far from extinct species. *BMJ*, *302*(6783), 1002–1005. doi:10.1136/bmj.302.6783.1002

Webb, P. T. (2002). Teacher power: The exercise of professional autonomy in an era of strict accountability. *Teacher Development*, *6*(1), 47–62. doi:10.1080/13664530200200156

Weiss, G. & Wodak, R. (2008). *Critical Discourse Analysis*. Theory and Interdisciplinarity. Palgrave Macmillan.

Wellington, J. (2000). *Educational research: Contemporary issues and practical approaches*. London: Continuum.

Wennström, G. (1980). National health policy and medical education. *Medical Education*, *14*(Suppl 1), 36–38. doi:10.1111/j.1365-2923.1980.tb02290.x

White, C. (2003). GMC still seen as “doctors club” despite reforms. *BMJ (Clinical research ed)*, *327*(7416), 639.

Whitehead, C. R. (2011). *The Good Doctor in Medical Education 1910 - 2010* (Doctoral dissertation, University of Toronto).

Whitehead, C. R., Austin, Z., & Hodges, B. D. (2013). Continuing the competency debate: reflections on definitions and discourses. *Advances in health sciences education : theory and practice*, *18*(1), 123–127. doi:10.1007/s10459-012-9407-7

Whitehead, C. R., Hodges, B. D., & Austin, Z. (2013). Dissecting the doctor: from character to characteristics in North American medical education. *Advances in Health Sciences Education : Theory and Practice*, *18*(4), 687–699. doi:10.1007/s10459-012-9409-5

WHO. (2011a). *Patient safety curriculum guide: Multi-professional edition*. Geneva, Switzerland: World Health Organisation.

WHO. (2011b). *Patient safety in developing and transitional countries: New perspectives from Africa and the Eastern Mediterranean*. Geneva, Switzerland: World Health Organisation.

Wiest, A. L., Andrews, D. L., & Giardina, M. D. (2015). Training the body for healthism: Reifying vitality in and through the clinical gaze of the neoliberal fitness club. *Review of Education, Pedagogy, and Cultural Studies*, *37*(1), 21–40. doi:10.1080/10714413.2015.988505

Wilson, R. (2006). Policy analysis as policy advice. In M. Moran, M. Rein, & R. E. Goodin (Eds.), *The oxford handbook of public policy* (Chap. 7, pp. 152–168). Oxford, UK: Oxford University Press.

Wilson, R., Michel, P., Olsen, S., Gibberd, R., Vincent, C., El-Assady, R., …, Sahel, A., et al. (2012). Patient safety in developing countries: Retrospective estimation of scale and nature of harm to patients in hospital. *Bmj*, *344*, e832. doi:10.1136/bmj.e832

Winship, C. (2006). Policy analysis as problem solving. In M. Moran, M. Rein, & R. E. Goodin (Eds.), *The oxford handbook of public policy* (Chap. 5, pp. 109–123). Oxford, UK: Oxford University Press.

Wise, J. (2016). The weekend effect: How strong is the evidence? *BMJ*, *353*, i2781. doi:10.1136/bmj.i2781

Woodside-Jiron, H. (2011). Language, power and participation: Using critical discourse analysis to make sense of public policy. In R. Rogers (Ed.), *An introduction to critical discourse analysis in education* (2nd ed., Chap. 8, pp. 154–182). Routledge.

Woolf, S. H. (2004). Patient safety is not enough: Targeting quality improvements to optimize the health of the population. *Annals of Internal Medicine*, *140*(1), 33–36. doi:10.7326/0003-4819-140-1-200401060-00009

Yanow, D. (2000). *Conducting interpretive policy analysis*. Qualitative Research Methods Series. Thousand Oaks, California: SAGE Publications. doi:10.4135/9781412983747

Yanow, D. (2007a). Interpretation in policy analysis: On methods and practice. *Critical Policy Studies*, *1*(1), 110–122. doi:10.1080/19460171.2007.9518511

Yanow, D. (2007b). Qualitative-Interpretive methods in policy research. In F. Fischer, G. J. Miller, & M. S. Sidney (Eds.), *Handbook of public policy analysis: Theory, politics, and methods* (Chap. 27, pp. 405–415). Boca Raton, FL: CRC Press.

Yeatman, A. (1990). *Bureaucrats, technocrats, femocrats: Essays on the contemporary Australian state*. Sydney: Allen and Unwin.

Zenz, T., Osterberg, J., & Kraft, J. (1998). Clinical experience of UK medical students. *The Lancet*, *351*(9119), 1894. doi:10.1016/S0140-6736(05)78852-8

Ziv, A., Small, S. D., & Wolpe, P. R. (2000). Patient safety and simulation-based medical education. *Medical teacher*, *22*(5), 489–495. doi:10.1080/01421590050110777

Appendices

A | Analytical Corpus

This appendix contains a list of the key documents forming the analytical corpus for this thesis categorised according to the convention proposed by Burnham et al. (2008).

Main policy documents

TITLE	TYPE	CATEGORY	CITATION
Promoting excellence: standards for medical education and training	Policy Document	Primary	GMC, 2015c
Tomorrow's Doctors: Outcomes and standards for undergraduate medical education	Policy Document	Primary	GMC, 2009
Tomorrow's Doctors	Policy Document	Primary	GMC, 2003
Tomorrow's Doctors: Recommendations on undergraduate medical education	Policy Document	Primary	GMC, 1993

Related guidance and policy documents

TITLE	TYPE	CATEGORY	CITATION
GMC | FAQS for UK medical students	Web Information	Secondary	GMC, 2016a

GMC | Our role	Web Information	Secondary	GMC, 2016b
GMC | Our role approving trainers, training environments and curricula	Web Information	Secondary	GMC, 2016c
Outcomes for provisionally registered doctors with a licence to practise (The Trainee Doctor)	Annex to *Promoting Excellence* (GMC, 2015c)	Secondary	GMC, 2015b
Outcomes for graduates (Tomorrow's Doctors)	Annex to *Promoting Excellence* (GMC, 2015c)	Secondary	GMC, 2015a
New medical education and training standards	Meeting Papers	Primary	Osgood, 2015
The state of medical education and practice in the UK	Report	Secondary	GMC, 2015d
Good Medical Practice 2013	Official guidance 2013 –	Secondary	GMC, 2013f
Doctors' use of social media	Official Guidance	Secondary	GMC, 2013a
Education and training standards review	Meeting Papers	Primary	GMC, 2013b
GMC | Bodies awarding UK medical degrees	Web Information	Secondary	GMC, 2013c
GMC | Education and training	Web Information	Secondary	GMC, 2013d
Good Medical Practice (2006)	Official Guidance 2006 – 2013	Secondary	GMC, 2001
Good Medical Practice (2001)	Official guidance 2001 – 2006	Secondary	GMC, 2001

B | Timeline

This appendix contains a timeline relating the publication of the UK medical education policy to key events in the medical and sociopolitical environment.

Table B.1: Timeline of key policy dates and related events

1983	Medical Act 1983.
1987	Margaret Thatcher's Conservative Government elected.
1992	John Major's Conservative government elected.
1993	**Publication of *Tomorrow's Doctors* (GMC, 1993).**
1997	Tony Blair's New Labour government elected.
2000	Harold Shipman Inquiry begins.
2001	Tony Blair's New Labour government elected.
2001	Royal Liverpool Children's Inquiry (Alder Hey) report published.
2001	The Bristol Royal Infirmary Inquiry published.
2003	**Publication of *Tomorrow's Doctors* (GMC, 2003).**
2005	Tony Blair/Gordon Brown's New Labour government elected.
2009	**Publication of *Tomorrow's Doctors* (GMC, 2009).**
2009	Investigation into Mid Staffordshire NHS Foundation Trust published.
2010	David Cameron's Conservative/Liberal Democrat Coalition government elected.
2010	The Redfern Inquiry into human tissue analysis in UK nuclear facilities published.
2010	GMC review of the future of regulation of medical education and training.
2012	GMC review of impact of Tomorrow's Doctors 2009.
2013	GMC review of education and training standards.
2015	David Cameron's Conservative government elected.
2015	**Publication of *Promoting Excellence* (GMC, 2015).**

C | Using the WPR tool

This appendix contains a snippet of a table utilised to map the policy problematisations to the questions derived from the WPR tool.

Policy	Categories	What is the Problem represented to be; and how is it articulated in the text?	What presuppositions, assumptions and presumptions underlie this representation? [Archaeology] - binaries, key concepts, categories	How has this problem representation come about? [Genealogy of problems]	Unproblematic issues, the silences, can the problem be thought of differently?	What effects are produced by this representation of the problem? Discursive, subjectification, lived effects	How is the problem produced, disseminated and defended?	How can the problem be questioned, disrupted and/or replaced?
PE 2015	**Patient Safety**	Problem: Individual choice. "good medical students and doctors make the care of their patients their first concern" p5. Concern implies an intention rather than an activity.	Definition of good (and bad) doctor contentious. Good-bad binaries, good doctor key concept. Patient safety as reducible to actions of doctors/learners. Introspective - doctors to review their own practice. Harold Shipman may have made patient care his first concern. Individual responsibility - and an assumption of clear objective insight into one's own actions.	Good doctor discourse. Competence, Attitudes, Skills and knowledge. GMC previously harranged as doctor's club - effectively communicating it is no longer for the protection of doctors.	Doctor attributes irreducible to skills, competencies, etc. Who's responsibility if patient safety, just doctors/learners or entire organisation, government and society? What is the role of organisations in ensuring patient safety? What is the role of government? What is the role of patients themselves? Patient harm is not only due to actions of the workforce but importantly the environment - hospital acquired infections, etc, and at times the treatments themselves - e.g. adverse effects of drugs and other treatments. Problem may be	Panoptic medical education and training. Doctors/learners are the problem so shine the spotlight on them. 360 degree feedback and obsession with documentation and "evidence". Reduction in dependence on clinical acumen and instead a move to adherence to standards and evidence-based practice. Spotlight is taken away from the government's responsibility to ensure the welfare and health of all its citizens, to errors and omissions of individuals and organisations.	Media coverage of patient related issues with blame being put on individuals and rarely organisations. Even where systematic errors are discovered the blame is put on particular individuals - not on the organisations themselves - or the state as having the ultimate responsibility over healthcare.	To what extent is medical education in the UK subservient to the NHS?
		Problem: patient welfare. "Patient safety is inseparable from a good learning environment" p5. Signal change in focus from risk to patients from learners - to ensuring learning happens where patients are safe.	Definition of Good. Learning environment afford lots of opps to practice. Safety as synonymous with absence of adverse effects or errors rather than welfare. Medical education and training in some way unsafe.	Entwistle - approaches to learning leading to focus on learning environment. Not the individual but the environment of learning. Medical errors and scandals - not just by learners but also by independent specialists.	Patient safety may be compromised by learning. Learning may not be best done in patient environment. No challenge to learning in this environ. Patient safety different in different contexts - more GMC disciplinary action against foreign-trained doctors. Again link to funding of education and training - this time funding and resourcing of good learning environments that are also safe for patients.	Where patient safety is first concern, learning has to play second fiddle. Service over training, reduced opportunities for training and education. Reduced experiential learning. Learning has to continue as consultant - with mentors. Growing distinction between junior and senior consultants. Move towards consultant led services, and reduction in training opportunities. long term risk to workforce.	GMC publications on patient safety. Subject of parliamentary debates, written statements and spoken references (Hansard). NHS trusts ranked on learning from mistakes (BBC), media reports on patient safety and medical errors. Patient safety watchdog appointed (BBC 2001), Too many avoidable errors in patient care, says report	Focus is placed on making patients better rather than on keeping people from illness - particularly preventable illness. If focus is placed on preventing illness and facilitating health of all citizens, then the issue is more one of state provision rather than one of organisations responsibility.
	Learning environment and culture	Problem: Values. "Education and training should be a valued part of the organisational culture"	Education is for occupational placement other than all other educational benefits. Organisations hold shared (as opposed to merely 'declared') values and these are shared	Functionalist view of education as ensuring core knowledge, values and skills for desired social function are delivered in a form that maintains a sense of social control.	The vast majority of medical education and training occurs in organisations whose primary focus is patient care. This primary focus is	division of organisations into educational and service deliverers - e.g. teaching hospital and district hospital. While medical education happens wherever medical practice occurs this	Mainly produced and disseminated in GMC publications but more recently the media coverage over junior doctors contracts and weekend working have turned the spotlight on education and training - not as a responsibility of organisations but that of	Ensuring adequate remuneration for learners supporting a healthservice in unsocil hours
		Problem: Individual/organisational responsibility. "Local education providers \ldots{} are accountable" for the disbursement of resources for medical education. Medical schools, Local education and training boards (LETBs) in England, and Postgraduate deaneries in NI, Scotland and Wales leverage contracts and agreements.	Individual responsibility and market dynamics - it is up to individuals and individual organisations to choose how to disburse resources. Competition, even at this level is desirable	Individual responsibility - now stretching beyond individual humans to individual groups and organisations. Implies devolution of such responsibility from Government or quasi-governmental bodies.	Variation in provision of education and training means some will get poor learning experience. Resource disbursement, especially in the light of a focus on patient care, may mean reduction in resources for education and training. It is the fear of punitive action that drives organisations to meet these requirements. Failure to meet them means loss of licence to operate or other regulatory action.	Learners are dependent on LEP's and subservient to patients. Training can be interrupted in order to facilitate resource distribution elsewhere. Precarious balance between education/training and patient care drives compromise in both rather than "driving up standards".	While the GMC asserts a move away from a focus on patient safety as a reduction in care errors it still articulates the need for organisations to facilitate whistleblowing on issues of patient safety.	
		Problem: Workforce distribution. Supervision of learner activity. Asserts need for appropriate clinical supervision.	Workforce distribution, and its funding and resourcing is favourable for BOTH learning and health care practice. No shortage or unfair distribution of workforce	Neoliberal notions of workforce development and distribution. Interplay between patient safety and learner needs - prompted by media coverage of medical errors and scandals.	Funding for provision of qualified clinical supervisors. Funding of medical education and training as opposed to funding for healthcare. Requirement for education training for otherwise clinically qualified supervisors.	Redistribution of workforce between healthcare and education limits resource available to either one. Creation of a new class of "clinical academic" part funded by D-H and part by educational institutions. Evolution of new academic specialities to cater for new staff. New clinical academic staff only provide healthcare on a limited part time basis with teh rest of their time spent in normal academic tasks.	Ministerial pronouncements, parliamentary debates and media coverage of consultant-led services, weekend working and doctors contracts	Can be rethought as inadequate supply - positions of consultants - tight control on specialist training and consultant numbers, a result of central control. These numbers presumably limited by funding and projections of workforce requirements for NHS. ON the one hand linking the number of training posts to NHS workforce requirements ensures an adequate workforce, while on the other it limits the flexibility to ensure adquate numbers of qualified staff to replace those leaving the service - as it is dependent on the numbers

D An overview of the themes in Promoting Excellence 2015

This appendix contains an extract from the *Promoting Excellence* (GMC, 2015c) policy showing the relationship of its standards and themes.

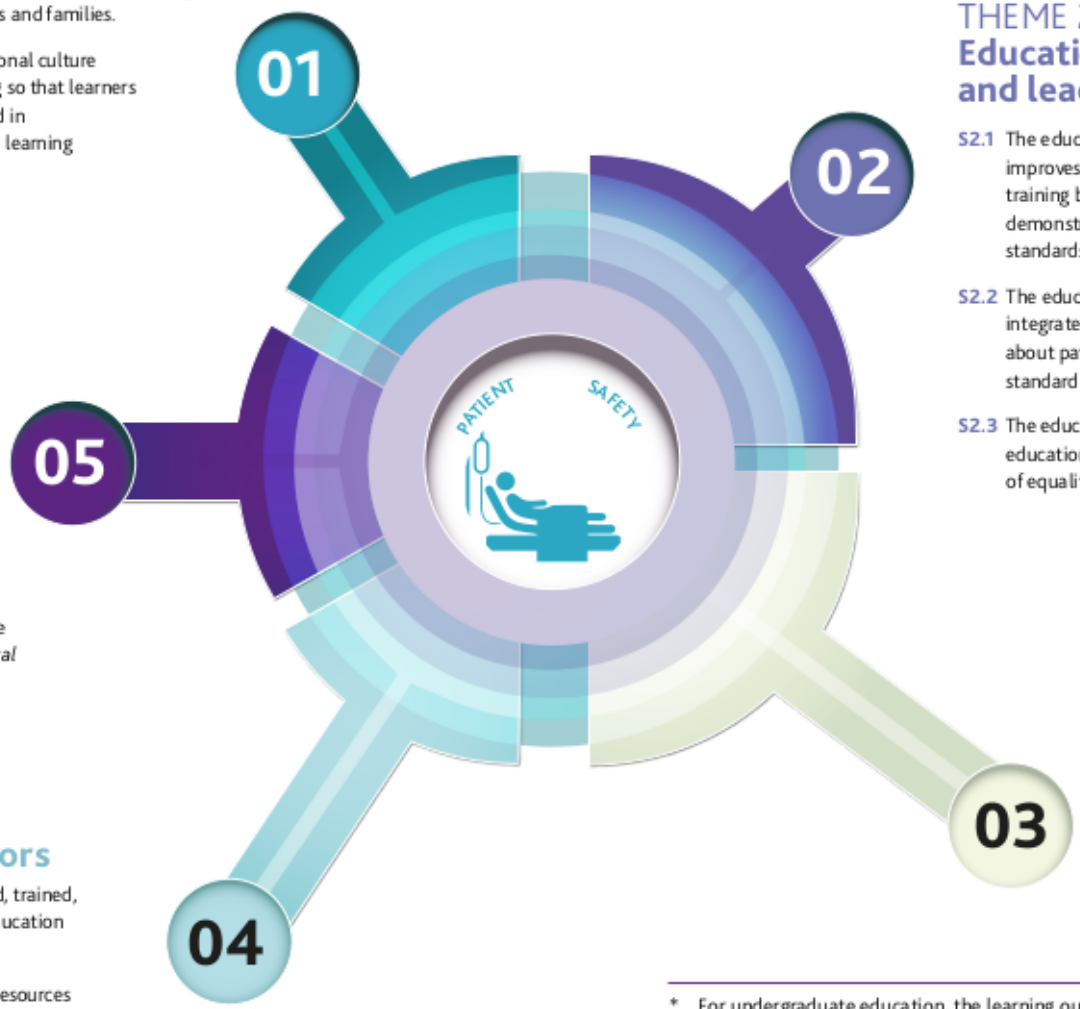
Promoting excellence: standards for medical education and training

The ten standards

THEME 1
Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.*



THEME 2
Educational governance and leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

THEME 3
Supporting learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

THEME 4
Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

THEME 5
Developing and implementing curricula and assessments

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

* For undergraduate education, the learning outcomes for graduates (*Tomorrow's Doctors*)[2] and for postgraduate training, the curriculum approved by the General Medical Council.